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ABSTRACT

Proceedings of the March 1987 Workshop on Health Manpower Shortage Area (HMSA) Designation are presented. The workshop was designed to facilitate cooperative efforts among the different federal and state health agencies that are involved in the planning and delivery of health care services. Contents include: a review of the mission and organization of the Health Resources and Services Administration, background information on health manpower shortage area designation, the current criteria for designating shortage areas, and the role of state agencies. Additional contents cover: trends in the geographic distribution and diffusion of physicians; current criteria and guidelines for designating HMSAs; methods employed by state agencies in geographic HMSA designation; federal programs related to HMSA designation; the National Health Service Corps; the involvement of professional associations in the HMSA process/data; methods employed by state agencies in population group HMSA designation; state programs involved in HMSA designation; and current developments in HMSA designations. Appended are a workshop agenda and a list of participants. (SW)

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BUREAU OF HEALTH PROFESSIONS

HEALTH MANPOWER SHORTAGE AREA DESIGNATION WORKSHOP

VOLUME II

SAN DIEGO, CALIFORNIA
MARCH 11-13, 1987

934

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HEALTH RESOURCES
AND SERVICES ADMINISTRATION

HEALTH MANPOWER SHORTAGE AREA DESIGNATION WORKSHOP

VOLUME II

SAN DIEGO, CALIFORNIA
MARCH 11-13, 1987

September 1987

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
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Bureau of Health Professions
Office of Data Analysis and Management

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INTRODUCTION

The Bureau of Health Professions of the Health Resources and Services Administration (HRSA) sponsored a Workshop on Health Manpower Shortage Designations. The workshop was held from March 11-13, 1987 at the Vacation Village Hotel in San Diego, California. It was attended by representatives from the state health and health planning agencies in Regions I, II, VIII, IX and X; Bureau of Health Professions, HRSA; Bureau of Health Care Delivery and Assistance and professional health associations. A list of participants who attended the workshop is presented in Appendix A.

The program for designating areas in which shortages of health manpower exist is administered by the Office of Data Analysis and Management under the Bureau of Health Professions. The success of the designation process and its effectiveness in alleviating health manpower shortages is dependent on the interaction among the different Federal and state health agencies involved in the planning and delivery of health care services. Thus, the purpose of the workshop was to facilitate cooperative efforts among these groups in achieving this goal.

The workshop was chaired by Howard V. Stambler, Director of the Office of Data Analysis and Management, Bureau of Health Professions, Health Resources and Services Administration, and Richard C. Lee, Chief of the Distribution and Shortage Analysis Branch, Office of Data Analysis and Management. Presentations included a review of HRSA's mission and organization, background on shortage area designation, the current criteria for designating shortage areas and the role of state agencies. A copy of the workshop agenda is contained in Appendix B.

Following are the proceedings of the Workshop on Health Manpower Shortage Area Designation.

WORKSHOP PROCEEDINGS

WELCOME AND INTRODUCTORY REMARKS

Overview of ODAM/BHPr/HRSA Organization and Functions

Howard V. Stambler
Director, Office of Data Analysis
and Management, BHPr

MR. STAMBLER: Good morning; it is a pleasure to be here. My name is Howard Stambler and I am the Director of the Office of Data Analysis and Management of the Bureau of Health Professions, Health Resources and Services Administration. I would like to welcome you to the workshop on Health Manpower Shortage Area Designation.

The purpose of this workshop is to facilitate a better understanding, and therefore, a better functioning of the HMSA designation program. This program, administered by the Office of Data Analysis and Management, is designed to identify areas or population groups that are currently experiencing a shortage of personnel in various health care professions. Those designation areas and population groups become eligible to participate in a variety of HRSA programs, each of which is designed by Congress to alleviate health manpower shortages. The accuracy of the designations, and ultimately, the effectiveness of these programs, are dependent upon interaction between HRSA, ODAM (Office of Data Analysis and Management) and state and local agencies involved in health planning and health care delivery.

The relationship between health planning and health care delivery is to provide health care and access. This is done in a variety of ways. Only with your input can we do our job and utilize Federal resources appropriately. We hope the workshop results in a closer and more effective means of Federal, state and local cooperation in identifying the areas of need. We also hope to strengthen the lines of communication established via telephone and letter, as we feel it is important to become acquainted on a person-to-person basis.

I would like to tell you about the Office of Data Analysis and Management and its parent organizations. The Health Resource and Services Administration is one of five Public Health Service agencies. The other four -- the Centers for Disease Control; the Alcohol, Drug Abuse and Mental Health Administration; the Food and Drug Administration; and the National Institutes of Health, are more widely recognized. HRSA, founded in September 1982, is the newest of these Public Health Service agencies.

The Public Health Service is headed by the Secretary for Health, Dr. Robert E. Windom. Prior to becoming the Secretary for Health, Dr. Windom was a professor and a privately practicing MD.

The establishment of HRSA was to develop a single focus for various aspects of Federal health policy involving general health and resource issues relating to access, equity, quality and cost of care. HRSA also covers the planning and providing of direct medical treatment to individuals.

The new director of HRSA is Dr. David Sundwall, an MD from Utah. He worked for Senator Hatch on the Labor and Human Resources Committee and has been supporting the legislation covering HRSA programs and many health programs across the United States.

The agency is organized into four major units. The Bureau of Health Care Delivery, responsible for assuring health care services to underserved areas and special population groups, supports and operates the community health centers, supported in areas and/or populations without adequate access to health care.

Dr. Edward Martin, former deputy administrator of the HRSA, heads the Bureau of Health Care Delivery and Assistance. Within that agency is the National Health Service Corps. The National Health Service Corps' acting director, Jeff Human, is responsible for the various activities of the Corps.

The Bureau of Resource Development administers the programs related to health facilities, organ transplants, AIDS, and, soon, the maternal and child health, formerly the responsibility of the Bureau of Health Care Delivery and Assistance. The director, Dr. Daniel Whiteside of the Commission Corps, has been with the Federal government for about 25 years.

Another well-known component of HRSA is the Indian Health Service, the principal advocate for health care between the Federal government and Indian tribal resources. The Indian Health Service provides a large part of the health care and rehabilitative care to Native Americans. This component is directed by Dr. Everett Rhoades.

The final component is the Bureau of Health Professions, or BHPr. BHPr manages the development and use of health personnel and provides financial support to institutions and individuals with the objective of assuring access to care and educational opportunity for people.

The Bureau also supports a number of activities that affect not only the overall supply of health personnel, but also the education of individuals as well. BHPr works towards improving the curriculum in medical, nursing, dental and other health profession schools. Mr. Thomas Hatch is the director of BHPr.

The Bureau is composed of categorical units that are divisions: a nursing division; an associated and dental health professions division, and a medicare division, which deal with the specific categories named; a division of student assistance, which handles loans; a disadvantaged assistance division, which aids and conducts programs for the disadvantaged, including the Health Careers Opportunities Program, which provides funds for educational institutions to provide assistance for disadvantaged or minority groups.

Our own office is ODAM. We have several programs of which HMSA designation is one. We are responsible for the analytical activity program of the Bureau, whether in providing technical assistance to other parts of the Bureau, developing analytical plans, and coordinating the analytical activities. We also do a number of the Bureau's technical studies, develop models to predict supply, requirements and geographic distribution, and collect and compile data for our various data systems and analyses. We use a variety of sources for our data and set up computerized data bases to permit easy access to them. Our major system is the Area Resource File that is county based, containing 200,000 data elements used in a variety of different studies.

An important part of ODAM, needless to say, is the Distribution and Shortage Analysis Branch, directed by Richard Lee. This ODAM branch develops the HMSA criteria, obtains and evaluates data and works with you to clarify and properly identify shortage areas.

During the next few days, we hope to give you a better understanding of the program and its role within the Health Resources and Service Administration. We will also talk about many activities that relate to the HMSA program, and try to create a better understanding of what the program is, does and how it operates. Your input will be very valuable; we are looking for your responses towards issues, and your questions and suggestions. We hope to gain better insight into how we can work together towards a common goal.

Now I would like to introduce Richard Lee, Chief of the Distribution and Shortage Analysis Branch. He will be the moderator for this workshop.

BACKGROUND AND OVERVIEW OF HMSA DESIGNATION AND THIS WORKSHOP

Richard C. Lee
Chief, Distribution and Shortage Area
Analysis Branch, BHPr

MR. RICHARD LEE: As Howard mentioned, we cannot do our job without your help. We truly appreciate your involvement. Today we are going to talk about the process and criteria for designation and some of the history behind designation. Our agenda for this meeting will cover the following areas:

- An overview of the national supply and distribution figures.
- Responses from state agencies on their prospective HMSA designations.
- Small group discussions.
- Discussion of programs associated with the HMSA designation.
- Responses from professional organizations associated with the designation process.
- Discussion of the population group designation.
- Discussion of state programs and scholarship and loan programs.
- Current trends in the designation process as viewed by BHPr.
- Group discussion on current trends, possible solutions to problems and response to current program offerings.

I would like to introduce the HMSA designation staff: Phil Salladay is responsible for Regions V, VIII and X; David Brand is responsible for Regions IV, VI and IX; Robert Lauber is responsible for Regions I and II; and Melba Kokinos is responsible for Regions III and VII.

Health manpower shortage designations were originally authorized to provide physicians through the Assistance Act of 1976. This law amends the Public Health Service Act, creating a new section, Section 332, with specific requirements for the process of HMSA designation, and indicators to be used in HMSA criteria. The new criteria were developed and implemented effective October 1, 1970.

From 1974 to 1977, many critical health manpower shortage areas were used by the National Health Service Corps and were designated under published criteria as authorized in 1972. These included critical primary medical, dental and later, psychiatric shortage areas. New shortage areas were designated from 1971, which included physician shortage areas based on all physicians as opposed to a given set as used in current criteria. This applied to dental, optometry, podiatry, pharmacy and veterinary shortage areas as well.

The reason was because there was authority for loan repayment to anyone in these professions placed in a shortage area.

At one time, the loan repayment shortage areas were the responsibility of a group within the former Bureau of Health Manpower while the critical health manpower shortage areas were the responsibility of the National Health Service Corps. In 1975, the responsibility for those two programs were combined into one unit located in Los Angeles, the Resource Analysis Office. This office later evolved into the Bureau of Health Professions.

The congressional action of 1976 in developing a new section with specific requirements served to eliminiate the dichotomy between the two different definitions of shortage areas. Congress decided that additional variables between the population of practitioner ratio should be taken into consideration, including infant mortality, health status and access. The major thrust of this Act was to designate urban areas that were not as obviously in need and were being overlooked. Congress wanted designations of population groups and facilities as well as geographical areas. The specific facilities mentioned were prisons, state mental hospitals and public or non-profit private institutions. BHPr developed specific criteria for prisons and state mental hospitals, for public and non-profit private facilities serving a geographic area or population group with a shortage of health manpower.

Members of our staff drafted criteria procedures to meet these various requirements. We published final regulations in 1978, and updated these in 1980. We have included in your registration packet a copy of the 1980 regulations.

The legislation requires that we seek comments and recommendations on proposed designation from health agencies where active, from state health planning and development agencies (SHPDAs) when no health service agency is active and from the governor of each state. As a practice, we seek comments from state or local medical or dental societies, from state health and mental health departments in particular and other alternative sources when necessary. We ask the medical and dental societies to participate in the designation process at an early stage. We set up systems that automatically touch base with the state level medical or dental organization.

Any individual project or agency can make a request if the letter is sent on official letterhead. Our inital assumption is that the individual or agency submitting the request believes that there is a shortage area needing designation. We check the recorded facts against national data. Then we attempt to have the need for designation validated by someone in the local area. At times we have requests wherein a health care provider is not counted because they do not serve the poor.

If you are trying to determine whether the area is a shortage area on a geographic basis, those health care providers must be counted, even if they do not provide services to all people. If you are trying to determine whether the area has a shortage of physicians available for Medicaid recipients or to medically indigent or migrants, then physicians who do not serve those populations do not have to be counted. There must be a consensus as to who is serving the populations. Our office must validate this information at the state or local level before beginning the designation process.

During the period 1978 to 1981, HMSA criteria had first been published, and we were developing the first HMSA. We worked closely with other health systems agencies, as most HMSA requests came to our office. SHPDAs did not play an active role. As the activity by HSAs began to decline in 1981 and 1982, we began to improve our links with the state agencies and health workshops specifically oriented towards SHPDAs.

But, how do you coordinate with SHPDAs as the law requires if there are no SHPDAs? Some offices are eliminated or no longer able to provide coordination on HMSAs. As the situation changes in your state, your assistance in finding people at the state level who can provide input and help on changes to the HMSA list will be very valuable. Legally, the HMSA must be published in the Federal Register and reviewed on an annual basis. In fact, the review process is continuous. At any time, a new area can be designated or an old one updated or withdrawn. The process involves specific requests. We send these requests to HSA, SHPDA if there is one, and state medical or dental societies for review within 30 days. After that 30-day review period, we take the information we have received and try to make an initial determination based on that data. Generally, we make a few phone calls to fill in gaps in the data or answer any questions where there is a conflict between two pieces of data received.

This is very difficult if there is no one to turn to at the state level. We are always trying to find people to validate information. The first list of HMSAs was published in 1978. Since that time, we have published essentially one list each year in the Federal Register. The first few lists were small spots of the total of individual cases we had dealt with. In 1981, we conducted a review. The first was labeled an annual review in which the HSAs were asked to confirm the existing designations. That was done on a voluntary basis. In 1983, we had designations existing since 1978. The time had come for a major review. We had the 1980 census data available. We had 1981 national data from the AMA and the ADA among others. We could construct population practitioner ratios on the county level from national data.

We provided the HSAs, SHPDAs, state medical and dental societies with this information and requested a review of all the designations made prior to January 1, 1981, using 1980 and 1981 data for comparison purposes.

In the absence of area cooperation, we would use the national data to update the county-level designation on subcounty areas. Those not meeting the criteria were removed from the list. This task was quite extensive, far more difficult than anticipated, taking until April 1984 to complete. In 1983, 22 percent of the HMSAs were designated. This led to a significant number of appeals with a number of areas being restored to the list after the necessary data were provided. We have since made an effort to institutionalize the annual review process. HMSAs designated in 1981 not covered initially were reviewed in 1983, and HMSAs designated in 1982 were examined in 1985. This past year we have reviewed 1983 designations and those last updated in 1984. We have also been conducting a major review of psychiatric HMSAs.

In the coming year, your task is to review all 1984 designations. This is a significant number of reviews, and we are all working with small staffs. Our major focus is to review those areas that have experienced significant change. These annual reviews guarantee that personnel and other Federal sources are allocated only to legitimate, recently updated HMSAs.

As mentioned earlier, in the future we will see an increasing number of population group designation requests. The distribution of physicians has improved, but there are still population groups with access problems in some states, most notably Medicaid eligibles and medically indigent.

We are searching for ways to more effectively control population group designations. The statistics on the number of HMSAs showed a dramatic increase in 1984. During the same period, the National Health Service Corps peaked. (More later on the National Health Service Corps.) Next year and in the future there will be very few National Health Service Corps service people to place.

The National Health Service Corps is beginning to work with the private sector. It places physicians in HMSAs, in some cases these are volunteer members. They also place physicians looking for a location wherein they can be of use. There will be a continued effort although the number of actual HMSA placements are smaller.

OVERVIEW OF HEALTH PERSONNEL DEVELOPMENTS AND PROJECTIONS:

Trends in Geographic Distribution Diffusion of Physicians

Howard V. Stambler
Director, Office of Data Analysis and Management, BHPr

MR. STAMBLER: It occurs to us that we do not fully understand the local viewpoint. Also, it seems that the local people often do not fully understand the Federal viewpoint. I would like to give you an overview of some of the national trends and developments in health manpower and health supply, distribution, requirements and future trends on health manpower and supply.

We are undergoing a period of tremendous change in health care delivery, hospital lengths of stay are decreasing and hospital outpatient visits are increasing rapidly. There are significant changes in the ways in which care is being provided and in the organization of health care delivery. In many respects there is confusion about the impact of these new types of organizations. Payment systems are also changing. Because of these changes I would like to show you some charts that we have developed over the last six months to help you visualize the important developments in the health care field.

Health is one of the largest industries in the United States. In 1985, national health expenditures amounted to approximately $445 billion, nearly 11 percent of the gross national product and $1,700 for every person in the United States. We are spending three times as much as we did just ten years ago. Thus, it is easy to see why cost containment issues are causing concern in the Federal sector.

During the same period of increasing expenditures, there was also a tremendous increase in all categories of health professionals, spanning 1970 through 1985. There were increases in that 15-year period ranging from 28 percent for optometry to 84 percent for registered nurses. Since population increased only 16 percent, all disciplines have increased their ratio to population.

Let us look at a few of the individual fields. The number of physicians has more than doubled in the last 25 years. In 1961, there were 250,000 physicians, while in 1985 there were over 525,000. From 1970 to 1985, a 15-year period, there was an increase of 200,000, a 62 percent rise. The physician/population ratio has risen almost as sharply. In 1970, there were 174 physicians per 100,000 persons, and in 1985, the figure was 220 per 100,000.

Another field of interest is primary care. The increase in this group has been similar to that of total physicians. It has risen by roughly a third in the recent period. However, the primary care specialties as a proportion of all physicians have increased only slightly. Family medicine has had the smallest increase of any of the medical specialties due to the large decrease of general practitioners in the 1970s.

Psychiatrists have experienced approximately a one-third increase during this period, a large number of whom are foreign graduates. Many psychiatry residencies are taken by foreign medical graduates.

Dentists have seen a moderate increase in this period, 38 percent. The dentist-to-population ratio has risen slightly; 50 per 100,000 in 1970, to 58 per 100,000 in 1985. There are also concerns about dental school closings and demand shortages within the industry. There is some concern about the reduced dental applicants in the dental education field.

Our projections for the future of health personnel supply show first year enrollments edging down, but with actual increases in the number of personnel. Population is expected to grow by roughly 14 percent. The increases among health professionals, even with the declining enrollments in some fields, will still be quite large. Between 1985 and 2000, osteopathic medicine is likley to double. Podiatry is facing a 75 percent increase. Dentistry, psychiatry and pharmacy will experience the smallest increases. But, since population growth is slower than most of those increases, population ratios will continue to raise. We will continue to have more physicians and dentists per population than in the past.

FROM THE FLOOR: Is nursing expected to experience an increase?

MR. STAMBLER: We expect about an 83 percent increase for nursing. There is much discussion about this because admissions are going down in nursing schools. But, unless we have a large movement out of the field, the nursing supply increase will be approximately that magnitude. Overall increases will be seen in the whole health manpower field.

There will also be a tremendous increase in the number of women in the health field. For instance, in medicine we have had an increase from about 22,000 in 1970 to nearly 56,000 in 1980 and to about 73,000 in 1985. The number of women in medicine has gone from 6.7 percent of all MDs in 1970 to 14 percent in 1985. By the year 2000 we expect the number of female practitioners in medicine, for an example, to reach 145,000. Increases will occur in almost every one of the fields between the years 1985 and 2000 in the proportion of women practitioners. This has a great many implications for the way medicine, dentistry and the other health care professions are practiced. This also has implications for the different specialties and geographic distribution, among others.

Quite often there is a tendency to forget that women do things differently than men, whether we like it or not. They are very different in the sense of what women do in their practices. The specialties with the large growth of women will thus have a major impact by the year 2000. The direction it will take is not absolutely certain yet.

Here are just a few numbers on physicians: the past 15 years show a growth of about 25 percent -- in the past five years it has risen another ten percent. Over the next 15 years we look for roughly another 40 percent increase in the number of physicians, a little bit slower than in the past 15 years, but still an increase of significant magnitude. This is pretty well set, not in terms of the numbers in school or enrollments, but in terms of how many will be in practice in those years. There can not be too many changes in what takes place in those future years. Again, in the past 15 years we had a ratio of 156 per 100,000 population, reaching 211 per 100,000 in 1985. Now we expect that ratio of physicians-to-population to reach 260 per 100,000 by the year 2000, a very significant increase even in the face of what could or might happen in the next few years in our medical schools. This graph shows the number of primary care physicians in the year 2000. We expect around 230,000 primary care physicians in the year 2000 compared to roughly 200,000 currently. We will have about a 35 percent increase in the primary care field. The number of primary care physicians is going to increase but, as a proportion of all physicians, we expect almost no change from the current levels. The other physician specialties will grow more rapidly. This chart shows the number of MD specialties in the important fields that we have looked at -- GP and FP.

For dentists we mentioned that in 1970 there were 102,000 dentists and in 1985 about 142,000. Future increases in dentistry will be slower. We look for about 160,000 dentists in the year 2000 or 59 - 60 per 100,000 population, a slower growth than in the past, and a much slower growth than in some of the other fields, as a matter of fact, only about a third of the others' rate of increase.

The number of psychiatrists shows pretty much the same kind of picture, a slowing down in their growth rate, reaching something on the order of about 38,000 in the projected year.

Overall, we will have a more than an adequate supply of physicians, with some areas actually in surplus. From this chart, you can see the requirements in the year 2000 will be less than the available supply. This does not mean that anybody expects physicians to be driving taxicabs, but it does mean a change in their basic approach to the delivery of care, the basic ways in which care is provided and its location. There are a great many concerns about what this ultimately means.

I would like to conclude with a brief look at the geographic distribution of physicians. All areas of the country benefited from this past supply increase. The drop in physician supply in rural areas has actually been reversed in the last 15 years. For a period of time, we were actually losing physicians because of the loss of the older general practitioners and the physician ratio was actually dropping. In the last ten years, the increase in family practitioner graduates has offset the decline from the deaths and retirements of old time GPs. As a result, from 1980 to 1985 the number of MDs in patient care in rural areas grew from 49,000 to 59,000, which is a 20 percent increase as opposed to a slighlty smaller increase in the urban areas, something we had not seen before. It appears that the FP supply increase will also help the situation in the more rural areas in the future because family practitioners and the younger physicians appear to find the rural areas moderately attractive. The increase from 1980 to 1985 was from 49,000 to 59,000. That was a 20 percent increase in the rural areas, as compared to a 19 percent increase in the urban areas. This faster increase is not really that significant; the significance of having similar increases helps us think the rural areas may begin to catch up.

MR. PETERSON: We show about a 40 percent decline in our rural areas of South Dakota.

MR. STAMBLER: It may not be true for South Dakota, but on a national basis it is certainly so. It is important, however, as you suggest to define the term "rural." They very often are defined differently.

In summation, the number of physicians relative to population has contributed to a decrease in designated HMSAs as well. We expect the number of primary care HMSAs to decline further in the next ten years. About two-thirds of those HMSAs are in rural areas. The bottom line is that we expect a continuing increase in supply, improved access for some population groups and some areas, although population and economic factors will not be very favorable for establishment of practices in many rural areas and many urban poverty areas. Thus, we believe we will be in the business of HMSA designation as population groups and others remain short of health manpower. It will not be easy to identify those areas.

MR. GOSSERT: This is not really a health manpower question, but under some new legislation it is theoretically possible for a government to designate an underserved area. The Colorado Congress has mailed out this information, but I understand there are no regulations yet. That has obvious implications for HMSA designation placements of manpower. Have you given thought to the implications of that?

MR. STAMBLER: We will talk more about that later. You are talking about the medically underserved areas. Not the health manpower shortage areas. Dick will answer that later since we have been involved in it.

MR. LEE: I was going to address that later, but probably not until Friday. What you are referring to is a bill Congress passed requiring that criteria for medically underserved areas, different from HMSAs, be developed under regulations to be published in the Federal Register. We already have the HMSA regulations, everybody knows the criteria and what the process is. They want a set of criteria for medically underserved areas that is clearly defined. This will be used for the grant funding of community health centers, migrant health centers and others. It is an acceptable designation. It is more oriented towards populations theoretically than towards areas. The regulations have not been published. Your point is that there is a loophole in that statute that says that governors can arbitrarily define an area, which would create a problem. If there was no criteria, my understanding is that their intent is to try to closely define that loophole. But it is a separate designation from HMSAs. I do have a copy of it. I will address this issue in more detail later.

MR. STAMBLER: Dick did not really mean loophole. It just left open the process so that, without criteria, there would be no differentiation or discrimination among its components. We want to give the governors an opportunity to put their views to work for certain kinds of exceptions. Until the regulations are completed, available, reviewed and published, we do not know how that will turn out.

Any other questions on any of the parts of my presentation? If you have no questions, we will recess for 15 minutes.

CURRENT HMSA CRITERIA AND GUIDELINES; DESIGNATION PROCEDURES

Phillip C. Salladay
Economist, Distribution and Shortage
Area Analysis Branch, BHPr

MR. SALLADAY: I want to begin with a quote from a speech that President Reagan gave last month (February) before an audience in Washington, D.C. The President said "The notion that central government holds the key to continued prosperity has gone the way of the hulahoop, the Nehru jacket and the all-asparagus diet." Unfortunately, and with all due respect to our President, economic prosperity and, closely correlated with it, access to primary health care has either yet to arrive or has come and gone for many people living in health manpower shortage areas. To underscore what Howard and Dick said, I would like to add that we do not view ourselves as central government planners, but rather as participants in a joint effort along with state and local health agencies and professional associations to identify those areas in population groups that continue to qualify as HMSAs. It is very important that areas and populations facing shortages of health care providers continue to be identified even though the Federal resources have declined in recent years. In addition to NHSC placements, the HMSA designations are used as a funding preference in nine Federal programs and as a determinant in 21 state programs. The Federal and state programs that make use of the HMSA designation will be discussed in greater detail later in this workshop.

Many of you present today are very familiar with the HMSA criteria and guidelines while some others are fairly new to working in this area. I want to devote some time to an overview of the criteria and tell you what we are looking for in the designation requests you submit to our office.

The regulations on which we base our determinations are the same ones we have been using for a while. The three essential elements that should be included in each designation request that is submitted to our office are (1) the rational service area definition; (2) the population-to-practitioner ratio; and (3) the consideration of contiguous area resources. The rational service area may be a single county, part or all of two or more counties, or an urban neighborhood. In some cases a rational service area may extend across state as well as county boundaries. There may be considerable variations in service area size due to the difference in population density. That subject has already come up in some of the discussions that have taken place this morning during the breaks. For instance, in the course of the HMSA review in New Jersey, which has 21 counties, we identified 22 sub-county areas, although they are not all designated at this time. In contrast to that, Owyhee County, Idaho, about the same size as the state of New Jersey, is divided into three rational service areas.

In the HMSA reviews that we initially conducted in 1978, many whole county rational service areas were requested by applicants and approved by our office. However, upon closer examination in subsequent reviews, we determined in a considerable number of cases that the rational service area for a population center may be, for instance, the eastern portion of one county and the western portion of the adjacent county. This closer analysis and subsequent listing of the census county divisions or townships that comprise these areas has resulted in more accurate service area definition but at a greater expense of staff time.

In determining a rational service area, it is often necessary to make a determination as to what the rational service areas are for the contiguous areas. It is very helpful if you include a map or maps that show the geopolitical boundaries of the requested area and the contiguous areas involved, travel distance between population centers, and any topographic features that are significant in defining the service area such as rivers, mountains, limited access, freeways or bridges. In some cases, it may be important to note the absence of bridges across rivers if that has a significant travel time. In urban areas, a map that delineates census tracts and if known, the established neighborhood boundaries is very helpful. It is also helpful if you indicate the location by census tract of hospitals and health centers as well as providers' offices. It is important particularly in urban areas that you provide us with some narrative description of the neighborhood or community. This should include description of the socio-economic characteristics and/or cultural characteristics that make the neighborhood distinct and limit interaction with other parts of the urban area.

After defining the appropriate rational service area, the population of the area should be determined. This will be data for the whole county using the most recent U.S. Census estimate or the most recent official state estimates from your particular state. For sub-county areas or census tracts in urban areas, a 1980 census adjusted population count that excludes inmates and armed forces personnel should be used.

The next data element to consider is the number of non-Federal full-time equivalent, or "FTE", providers practicing in the area. You should include all primary care physicians with practice addresses in the service area. Specific information should be provided on any physician counted as less than 1.0 FTE, such as other practice locations, time spent in teaching or administrative work or reduced practice due to age. For some cases where only the office hours of a physician are known, we have developed guidance for determining an FTE. A copy of this guidance is included in your packet. Also included in the packet is a one-page clarification on the definition of non-Federal as used in our practitioner counts.

In order to verify the total number of practitioners within a service area and the contiguous areas, it may be useful to begin with licensure and/or medical society data then cross check to the telephone directory. From this comes a list of names and a telephone survey can be conducted to determine active practice status and the number of hours per week in primary care. Additional information such as the amount of medical care provided to medically indigent or migrant workers should be requested if a population request group is being considered. The use of a mailed survey consisting of an explanatory letter and return-addressed postcard has been used by some applicants in developing an FTE count. Once the population-to-practitioner ratio of the area has been determined, the ratios for the contiguous areas should be calculated. Contiguous areas are those areas within 30 minutes travel time for primary care and 40 minutes travel time for dental and psychiatric care. Travel times are measured from the population center of the service area to the center of the contiguous areas. In non-metropolitan areas, highway travel times and distances should be provided. If they exist, please provide us with official state highway estimate of travel time. In inner-city areas where there is a dependence on public transportation, bus travel times should be used. Contiguous area ratios in excess of 2,000 to 1 for primary care, 3,000 to 1 for dental and 20,000 to 1 for psychiatric care are considered indicative of practitioners who cannot alleviate shortages in the service area. Barriers to access such as significant economic, cultural, or racial differences between the service area and contiguous area should be noted. Poverty rates of at least 20 percent are required as evidence of significant economic access barriers together with evidence of limited availability of Medicaid, public primary care services in the contiguous areas.

With regard to the factors indicating unusually high needs or insufficient capacity of the existing primary care providers in the service area, please provide most recent information for a five-year period on infant mortality and for births per thousand women age 15 to 44. I think in some cases we have rather old infant mortality and birth rate data in our data base. For dental requests please include information on the extent of flouridation of the area's water supply. That relates more to rural areas -- most urban areas have had flouridated water supplies for some time. For poverty rates, data from the 1980 census will be used except where more recent statistically valid estimates have been developed. In most cases extrapolation of an updated poverty level based on unemployment data have not been acceptable.

Now, I want to give some attention to population group requests. In some cases where we have determined that the general population of a geographic area is not facing a shortage of health care practitioners, there may be specific population groups residing in the area that are experiencing economic, cultural or linguistic barriers to access to health care providers. The request for a Medicaid-eligible designation for an area in Pittsburgh, which is included in your packet, is a good example. The area was rejected on a geographic basis but subsequently designated for a specific population group. The population groups that we consider for designation include poverty, Medicaid-eligible, medically indigent (defined as the poverty population minus Medicaid eligibles), migrant agricultural workers and their dependents and other populations isolated by cultural barriers or handicaps. A two-page handout on population groups and access barriers is also included in your packet.

After determining which group or combination of groups you want to request, the next piece of information you must develop is the area of residence for the population group. In rural areas or smaller cities the area of residence for a poverty or medically indigent population group may be a whole county while in larger urban areas it may be a group of census tracts with concentrations of persons facing similar access barriers, but not usually the entire county that comprises a major metropolitan area. The medically indigent designation request for the city of Pueblo, Colorado, included in your packet, represents a good example of the upper range in terms of size of an area of residence for an urban population group.

For migrant workers, the area of residence tends to be larger and may include two or three contiguous counties within the same growing and harvesting region. This would be the migrant's temporary area of residence. They, in fact, may be counted in several different harvesting regions over the course of the year and factored for the portion of the year they are present in each region. The population count for a poverty population request can be determined from the data in the 1980 census. The counts for migrant farmworkers and their dependents should be based on the most recent Federal or state labor estimates of the average number of migrants in the area multiplied by the factors of the area migrants that are present in the area. Estimates of the FTE amount of care being provided to migrants will usually require a survey. We will discuss issues relating to migrant counts and FTE surveys in further detail during the small group sessions tomorrow afternoon. Also, Paul McGinnis will be bringing up the migrant FTE issue in his state panel presentation.

For designation of Medicaid-eligible populations, information on the number of Medicaid eligibles by county is usually available from the state welfare department. The FTE count can be developed either through a survey of the primary care physicians or through an estimation of FTE based on county reimbursement data from the welfare department. When reimbursement data are used, if the data are not separated by physician's name and you are not able to determine who is primary care and who is not, then an estimate of the percentage that represents primary care must be applied. The amount of primary care reimbursment dollars should be divided by the average cost per visit. Then that number should be divided by the average number of office visits per primary care physician per year. That is either 5000 or a number that can be substantiated as appropriate for a particular state. This will yield the estimated FTE. This may sound a little complicated, but we do have examples that we will discuss in the small groups.

In cases where language is considered the significant barrier, the provider survey should specifically address the question of language in terms of number of practitioners who are either bilingual or employ bilingual staff. In addition to the geographic and population group designations, we do have criteria for designating facilities, including Federal and state correctional institutions, state mental hospitals and other public or non-profit private facilities. For the correctional institutions and state mental hospitals, it is usually a clear-cut determination based on inmate or inpatient data and FTE practitioner counts supplied by the respective department of corrections or state mental health authority. We do have one proposed change in the correctional facility criteria which Dick will discuss on Friday. Also, with regard to public and non-profit private medical facilities, those can be reviewed to determine if they are located close to and serving designated geographic areas or population groups.

Beyond the individual requests we also have the annual review process, which Dick mentioned earlier this morning. We are currently completing our review of the primary care submissions received in 1986 for areas last designated or updated in 1983. In the next few months we will be developing our annual review request for 1987, which will emphasize those areas last updated in 1984. Due to the staff cutbacks which most of your agencies have experienced, we have been discussing how we can put out our annual review in a way that you can deal with it. We will try to help you work smarter and not harder on this one. We are going to attempt to reduce the amount of effort required on your part by maintaining the existing rational service areas definition except where significant changes have occured. We plan to use the 1985 primary care physician data from the AMA and the most recent available census population estimate by county in our primary care annual review data base. That is about all I have on the criteria and the guidelines.

We can open the floor up now for questions.

MS. CAGEN: I had a question about the ways that you would determine how many providers are in an area. You said you go to the licensor or the medical society.

MR. SALLADAY: I mentioned those are two sources that you could look at collectively and sort through the names and come up with a composite list.

MS. CAGEN: We had to go through this process recently because an area in our state wanted to be redesignated. We just found that these sources really are not that accurate or up to date. For instance, in Rhode Island, physicians are categorized by their residence and not where they practice. It is kept by the Office and Department of Health and the licenses of the physician. We had done a survey that they called the relicensure survey. Only 85 percent of physicians have responded to that as it is not mandatory. The medical society was no help as they did not know where the physicians were practicing either. The Yellow Pages was of some help but it is already a year old in some cases. How do we know we are really getting all the figures in an area because some doctors have set up practice in the last six to nine months?

MR. SALLADAY: Another source of practitioner information may be hospital administrators because they usually know who is practicing in an area through the hospital referral patterns.

MR. LABREC: What works for smaller areas is asking the physicians if they know who practices in the area and using that as a starting point as well as the Yellow Pages.

MS. CAGEN: We did that. We gathered a few more names. Another major problem we had was conflicting information. We had two physicians who told us that they are, in fact, working a certain number of hours per week. The local health center was convinced that this was not correct. They are very upset because they felt that these doctors were basically lying. In particular, the center felt that one doctor was only working perhaps 12 hours per week. The doctor claimed she was open 48 hours per week. We had a telephone survey and a written survey of physicians. When we reported the information to the Feds we noted the discrepancy. We told the health center that notifying BHPr was at their option. Do you have any guidance on how to handle these things in the future when they come up?

MR. SALLADAY: From what you just said it appears in that case that you did a pretty exhaustive examination of the sources available. If it comes down to a question of one person's word against another, then at some point we must make a prudent determination based on all the information available. We try to do it as tactfully as possible.

MR. LEE: Trying to find some place to throw that hot potato? The problem comes up in many states, and some localities.

I know the case you are referring to and it has been a hot potato in the past. But as Phil said, when it comes down to the physician stating the number of hours per week worked, and we have special factors that we can translate that figure into full time equivalency, but if there is a clinic that says, no those figures are wrong, I do not think we are going to call the doctor a liar. What we try to do then is to document it as well as possible. Try to get the physicians or the medical society or someone to go on record. Then we use that. If the other organization has a problem with that, it is up to them to disprove the figures on record.

MR. SALLADAY: Any other questions or comments?

MR. GOSSERT: I just wanted to make sure I heard you when you said that updates of poverty level based on unemployment data generally have not been acceptable in the past.

MR. SALLADAY: In the past we had a number of cases where an applicant has attempted to extrapolate estimates of poverty population estimates from unemployment data. The unemployment data can vary so much from month to month and year to year. We have looked at a few cases such as this but they did not appear statistically valid. There was one recent case where we did receive updated poverty population estimates for an entire state. It has been done by an off-shoot of the old economic opportunity program, in Cleveland. They began with the city of Cleveland. Their methodology involved using food stamp participation rates. They came up with the correlation coefficient of .87 after weigting for some other variables. I would be glad to give you the reference on that report. It was done on a county basis. It is a good example of an update of poverty estimates that we did find to be acceptable.

MR. MCGINNIS: You mentioned briefly a cover letter that would go with survey instruments and so forth and the problems that this lady experienced. Could you touch briefly on the obligation of the person doing the survey to identify the purpose and the reason for the survey rather than finding out the facts of the matter and calling up and trying to get an appointment at four o'clock. That can easily determine whether or not that person is working those hours. Things such as posing as someone who has no ability to access the system and so forth.

MR. SALLADAY: In some localities there still seems to be considerable opposition from local practitioners to what is being proposed for designation. In some cases it is difficult to conduct a survey and get what could be considered a factual estimate of the FTE. Are you referring specifically to the migrant cases in Oregon?

MR. MCGINNIS: Whether or not we have some sort of an obligation to identify why and what we are doing before we try to find out how accessible those people are.

MR. SALLADAY: Generally, if it is a telephone survey the applicant would identify who they are. In terms of conducting the survey, I know there have been times when a person calls up a practitioner and asks in Spanish for an appointment. I have not had direct experience in reviewing that type of survey. Chris Walker, would you like to comment on this subject?

MS. WALKER: We were trying to get a designation for the Spanish population in Orange County. We would call practitioners, tell them who we are and do they have bilingual staff available. We collected one set of responses. Then, we would call in Spanish and request an appointment. We were referred to North County Health Service. You need to go over to the clinic and get a totally different set of information. I think it is imperative for us to find the truth.

MR. LABREC: I think the point is you can submit that kind of data (physician response to survey questions versus response to hypothetical patients). If you find a discrepancy between word and deed, point this out in your application. I think it would be admissable evidence.

MR. SALLADAY: We would take your submission and mail it out for comment to the interested parties. Then we would weigh your submission against the comments we receive. In some cases we may be getting knee jerk emotional reactions from a handful of providers in the area. Other cases, it may be a very well drafted rebuttal from the medical society in the particular area. These FTE count issues are handled by us on a case-by-case basis. It is one of our most difficult areas to deal with.

MR. LEE: I think this is a series of things. The best survey is usually a written survey because then you have hard documentation to show that the area meets the criteria. If you do a telephone survey, then you want to be able to document that you called all of the physicians and who you talked to. If you do what Chris mentioned and make two different phone calls, perhaps in two different languages or perhaps from two different prospectives, for example one call to ask if they serve the Medicaid eligible and the other as a Medicaid patient, then you need to fully document that what is being said is not what is being done. If it is as well documented as possible, it may well be considered substantiation.

MR. MCGINNIS: Usually you have to depend on the telephone. You will not get letters back.

MR. LEE: Sometimes it helps if you have sent a letter asking for information. Then you follow up by telephone. In some cases you generalize based on the response to the rest of the population. You have made the effort and they cannot say they were not asked to participate. The more you can do to go to the providers to get the information from them in a way that they can handle, the stronger it makes your case.

MS. ROGERS: I have found in one case that I was able to get an area designated despite the objections of some of the medical providers in that area. However, these same medical providers were able to discourage any physicians funded by the Federal government from practicing in that area by threatening malpractice suits. I have never been able to get physicians to come into an area over the objections of the local physicians.

MR. SALLADAY: That is an interesting point. If it is a smaller community then you may have a closely knit social structure among the established physicians. If they choose to ostracize an incoming National Health Service Corps physician, he would be in an uncomfortable position.

MS. ROGERS: It was our Wilton designated area. There was some local physicians who did not want a National Health Corps doctor in that area, even though they were not providing primary care. They had an emergency room clinic in the area and that was all. They just did not want competition.

MR. SALLADAY: We might ask Irma Honda if the National Health Service Corps has a perspective or strategy for dealing with those situations.

MS. HONDA: Well, the NHSC placement policy requires that we contact local medical societies before we finalize any match to a health manpower shortage area. The local medical society is invited to provide comments to us regarding the continued need of the service. If responses are negative, we divide those based on substance from those based on emotion. If local societies say that since the area was designated we have had three physicians move into the area and there is not an additional need, that is one response that will be dealt with in a very factual manner. It does not make sense to place physicians there. Most of the medical societies comment, "We do not want any Federal involvement. We are not providing any additional information."

Under those circumstances, it is resolved on a case-by-case basis. If a physician is going into a pure private practice and the local medical community is going to ostracize him or her, it doesn't make sense to place anyone in there because that practice is going to fail. If it is an organized system of care where there is a mechanism for providing the physician with income and that physician is needed and is providing services, the placement may be made in spite of local medical society objection.

MR. SALLADAY: Thank you, Irma. Any other questions?

MS. GLIDDEN: You referred to adjusting the FTE for physicians through their age. Could you give me an example of that?

MR. SALLADAY: I think I mentioned there may be physicians who have reduced their office hours due to age. We do not have a specific adjustment factor for age for primary care physicians. That would be, in most cases, reflected by a reduction in number of office hours, possibly termination of hospital privileges and on-call activities. The FTE guidelines are for use where only office hours are known. In some cases you may know a good deal about the physician's practice. Provide us with that information. We will come up with the appropriate FTE. Does that answer the question?

MS. HONDA: I have a related question. In instances where a physician does not have hospital privileges but does have at least 30 hours of office-based practice, is that physician still counted as a full time physician?

MR. SALLADAY: I think in most cases if it was shown that the 30 hours represented that physician's total active patient care, then we would count them as an .8. We have seen requests where you have a county with seven physicians and somehow they are all .8. We have looked upon those somewhat suspiciously. There are valid and justified reasons for counting a physician at less than 1.0., but we need the practice information to substantiate it.

MR. LEE: Many times we get a submission in which they have listed the physicans and their full-time equivilency as computed by whomever is submitting the request without showing where they got their figures. We need to know the basis of your figures. Is this simply based on office hours? We need that information as backup to understand why this particular area has so few physicians with .5 or something.

New Jersey comes to mind as we had a series of applications where every doctor seemed to be .5. It is one of those inner-city cases. The physicians had predominantly both an inner-city office and a suburban office. That is fine, but we need to have that information to make the request easier to understand.

MR. GOSSERT: A company out of Chicago provides updates of population and estimates. It is a computer based data set. I know our hospital association in Colorado belongs to it. I just wondered if those were acceptable estimates of population and if they would be available?

MR. SALLADAY: They may be. We have accepted population estimates for a given state if they are used by the state for other financial and planning purposes and represent the state's official estimate.

MR. STAMBLER: The National Planning Association makes projections based on the census. They move from whatever level the census produces to a county level. The physicians are also provided by another firm, Bowles and someone else. But those do not get down to a sub-county level.

MR. LEE: We regard these as decent projections at the county level. The only problem we have is in the criteria. Some of the forecasts are projected from the total county population. Others are projected from the total civilian population including institutional. We have to know which of the two it is. We were using a procedure that is different than what is called for in the criteria than to try to adjust it to the most recent census counts of the military and institutionalized in that county. Within those limits, those projections are probably acceptable. Also, a number of states have their own projections that are based in part on the 1980 census. Where it is the offical state projection that is used, we try not to get caught in the crossfire from different state agencies within the same state using different projections to determine what is the basic state projection.

MS. ROGERS: Are nursing home populations listed as institutionalized?

MR. SALLADAY: Good question. We checked on that very subject just before we came out to San Diego. The nursing home population is factored out when using the 1980 census adjusted population which also excludes the armed forces, college students living in dormitories and inmates of correctional institutions. The nursing home population issue also comes up in the case where a physician is identified as practicing exclusively in nursing homes. Do you want to add to that, Dick?

MR. LEE: Did that answer your question?

MS. ROGERS: I am not sure because our problem seems to be once a patient enters a nursing home the primary care physician forgets about them. It is very hard to get them to serve nursing homes.

MR. LEE: But the nursing home population is part of the institutional population?

MS. ROGERS: Yes. But they are in need of care.

MR. LEE: What you are saying is we are leaving these people out?

MS. ROGERS: I wonder if you are.

MR. LEE: That is a good point. If the question is this particular shortage county has a nursing home in it, then what you are saying is, if we ratio the physicians available to the general non-institutional population that takes care of them, but what about the institutional people; we do not have nursing home criteria.

MR. SALLADAY: I think the point you are bringing up is like the flip side of what we have experienced in most designation requests where the general population may be facing a shortage. Physicians are identified as specifically serving the nursing home population, and the applicant is trying to deduct that physician from the FTE count to get the county designated.

MS. ROGERS: I am talking about sub-county area. If you have a nursing home in that area, you are greatly increasing your need for physician services because it is hard to get doctors to serve the nursing home population. So, you do not count them. You are not counting people who have the greatest need.

MR. LEE: I guess it seems to me as though we could say, here is the population and it includes the nursing home population. We are going to specifically add that institutional population back in and see if there is a shortage. I think that could be done. If nothing else, it is a population group. You are combining that population group with the general population.

Phil, in his talk, referenced all the materials in the packet. One of the items is the guidelines that were published in the Federal Register on population group designations. Another is something that was developed subsequent to that. It specifically states what needs to be included in the population group request, developed in connection with the business about the bi-lingual people and how that is defined. In addition, it has come up in a number of cases particularly in Florida and Oregon as well as county wide in poverty population designations. We turned down some specific requests for county-wide poverty population designations and asked them to come back in for a neighborhood designation.

If a county has a population-to-physician ratio better than 2000 to 1, the county as a whole is not over-utilized and does not come close to being a shortage area. If the county poverty rate is lower than 20 percent poverty and particularly if it is a county where there is large numbers of physicians, as in Dade County, Florida, it is very difficult for us to designate the poverty population of that county because there are not statistics supporting that as a county with high poverty.

In those cases we ask the applicant to go the next step and find the population group, the neighborhood or the population group within a neighborhood. There are cases where county wide the poverty rate is 25 percent. The county-to-physician ratio is 2500 to 1. In those cases, we have done some county-wide poverty population estimations. It is something that I think is understandable but it is not written down in any materials that you have.

Are there questions on population groups or anything else?

MR. GOODMAY: If I may, I would like to back up to FTE for a moment. As I understand NHSC, the PPO docs are not to be considered FTEs. Is there some easy way of gaining access to the dates of their contracts? When they expire for example? How can I find out when I can start considering that one an FTE?

MR. LEE: You would go to your regional office.

MR. SALLADAY: In Region VIII, Marva Jackson is the person to contact for that information.

MR. LEE: She will be here tomorrow. Other questions, complaints?

Our plan is to reconvene at one o'clock. We will have the panel discussion of the two or three state representatives and then break into small groups by region.

(At this time a lunch recess was taken.)

PANEL DISCUSSION: State Agency Experience, Methods and Issues in Geographic HMSA Designation

Sophie Glidden, Maine
Justine Ceserano, New Jersey
Dave Peterson, South Dakota

MR. LEE: On the agenda for this afternoon is a panel discussion on state agency experience, methods and issues, as well as geographic HMSA designation. This would include FTE counts and most anything else that has come up in a particular state's experience. We will begin with Sophie Glidden from Maine.

MS. GLIDDEN: I want to thank the Federal government for inviting me down here out of the snow in the state of Maine. In Maine, we have a unique way of doing our designations that, I must admit, has cause some controversy over the past few years as to how you define a rational service area.

Back in 1978, when our first health manpower shortage areas were defined and designated, they were done on a hit or miss basis. We ended with counties or half counties that were designated sometimes spanning a distance in excess of a couple hundred miles. Well, we all know that a doctor who sits at one end of the hundred-mile area cannot cover that population at the other end of it. The staff of the health system agency (HSA), recognizing this, decided there must be a better and more equitable way of determining a health manpower shortage area.

Based upon the premise that there was an existing better way, they set about to define rational areas for Maine within which they could assess and determine what primary care services were available and what primary care services were needed. The end result, after extensive research, gave them 62 areas within which they could look at primary care services. They broke the state up into these 62 areas by reviewing the data that included everything from school districts to labor market areas, economic trade areas, transportation routes, hospital discharge data and existing primary care services.

The resultant 62 areas are shown here outlined in black. That is the first step in measuring areas against the HMSA criteria since the first criterion is the rational service area. Obviously, the second criterion is the population-to-physician ratio. We survey our physicians every two years in Maine. Based upon the surveys we then calculate our FTE using 40 hours as full time.

The third criterion, the contiguous area, is simple because most of our areas pretty much surround a population center. We measure out 30 minutes of travel time. As you can see, there is a fair amount of underserved areas in Maine. We have had some controversy on using just the primary care analysis areas. We do, however, have areas that are designated as shortage areas that are not primary care analysis areas; most of which have had a designation prior to the development of the primary care analysis areas. Some have been reevaluated since they were designated and recommended for continued designation. We have a group of islands off the coast of Portland and a group off the Rockland coast that are designated. But most of our designations adhere to the boundaries of the PCAAs.

Our psychiatric designations are done in line with our community mental health centers (CMHC). We have adopted their (CHMC) areas as the rational areas.

Our podiatric areas are still on a county-wide basis. We designate by county because, 1) we do not have many podiatrists to deal with and 2) needed population bases are greater and many counties do not have more than the population base needed for a defined podiatric area.

Our dental shortage areas, or dental care analysis areas, are similar to the primary care analysis areas. We have reduced the number to 45 analysis areas. They are roughly the same except in the northern and eastern sections of the state. We clumped some of those areas together because of their small population size.

We have found this method to be a very workable way of doing designations. Once you have your areas defined, you only have to look at your ratios and contiguous area resources.

MR. STAMBLER: We have that from a number of states. We tried to encourage all states at one time.

MS. GLIDDEN: The staff of the HSA began the PCAA identification process shortly before I began there in 1978. In June of 1979, the board of the HSA accepted the PCAAs as a base planning tool. In May of 1980, the governor accepted them for Maine to be used as the offical government planning areas. The HSA spent a fair amount of time in the research. The HSA staff took them to five sub-area councils and had public hearings held in five regions of the state so that everybody would have input into the development of the areas. Any changes or recommendations that resulted from those public hearings were incorporated. Finally, when they were fine-tuned, the PCAAs were accepted in 1979 and have been used ever since.

MR. LEE: Is there any need to update them as patterns change?

MS. GLIDDEN: I believe that we should go over them again and review the data. We will be doing that as time allows. I have found some towns that were borderline at the time of defining the PCAAs in the beginning. And as time goes on, as facilities close and new practices open, I think that it is evident that there will be some changes that should be reviewed.

MR. LEE: Do you have a process for doing that?

MS. GLIDDEN: It is not clear what the process will be now that the SHPDA is gone. The process, when P.L. 93-641 was in effect would have been for the petitioning party or the state to take them to the State Health Coordinating Council that would have reviewed them. We would have taken them out for public hearing and incorporated changes as a result. With health planning behind us, it is anybody's guess as to how the state will handle it.

MR. MCGINNIS: The base unit for data: how does that economic data help the transportation? Is it hard or does it match well to those sorts of things for other planning purposes besides the HMSA review? Do you have other data available?

MS. GLIDDEN: Our defined MCDs are our towns or cities. All of our data, (and we are wealthly when it comes to statistics), are accumulated for everything possible by MCD. I also use the PCAAs when I do medically underserved area analysis.

MR. MCGINNIS: But those areas then are incorporated communities. Those are the boundaries?

MS. GLIDDEN: Right. These darker lines indicate the counties and all this area has no one living in it. In fact, 80 percent of the population lives from this area down. The rest of the population basically live alongside Route 95. Then you have a smattering of potato farmers and pulp and paper workers up in here. All of the towns are blocked off here. Those lines are individual towns.

MR. GOODMAY: The northern border, Aroostook County, what is your relationship with the province of Canada? Do you ever do any joint designations?

MS. GLIDDEN: It is my understanding that joint designations do not exist because the population of the United States is not responsible for Canadians and vice versa. Because of that we have never attempted to do any joint planning. However, in the Madawaska area, many people have dual citizenship. They are eligible for all of the health care services available in Canada and in Maine, or in the U.S. if they happen to have Medicare or Medicaid. Edmunton, which is right across the border, has a tremendous amount of primary care services. They have a problem getting doctors to go into the Madawaska area because of the services available across the border. That has posed a problem for us.

MS. CAGEN: Some of the areas are awfully small. For instance, number 28. Is that because it is such a rural area?

MS. GLIDDEN: Number 28 is Jackman. It is located 45 miles from any other primary care services. There are people who live in between there but once you leave Jackman, you do not get to another doctor until you get to Greenville, which is this area. The next primary care services are about 45 miles. In fact, they tell me that Jackman, Maine was one of the first sites of the National Health Service Corps.

MS. CAGEN: So they have a National Health Service Corps physician there now?

MS. GLIDDEN: He is there full time. It has become a problem for him as he is an internist and does not have a hospital to practice out of. His commitment is up in June. His replacement is a NHSC person in our Maine residency program in Augusta. We hope the new doctor will have a little better acclimation to the area and will perhaps stay on indefinitely.

However, since the population is so small it is feasible that it could be covered by a semi-retired physician. They do get some patients from across the border. Jackman is surrounded by pulp cutters and loggers. Their base income is the wood. They have many forest accidents. And patients come from the Canadian province of Quebec. It is questionable that 1,300 people can provide a full-time practice although they did at one time have a private doctor there.

MR. SALLADAY: Thank you, Sophie, next we are going to hear from Justine Ceserano from New Jersey.

MS. CESERANO: I thought I would provide you with an overview of the entire state of New Jersey. I will be discussing some of the demographic characteristics of the entire state. I would then like to take a more in-depth look at two of our designated areas, Newark and South Sussex. These are two radically different types of areas. Then I would want to update you on the status of the HMSA designation activites in New Jersey.

The state of New Jersey with approximately 7.4 million residents and 7,836 miles is the most densely populated in the nation. The population is distributed unevenly throughout 21 counties and 567 municipalities. The most densely populated and highly industrialized municipalities are in the northeastern part of the state close to New York City. New Jersey last had 22 sub-county areas identified. Presently 11 areas of the state are designated as primary health care manpower shortage areas. We also have a few psychiatric and dental HMSA designations.

Designated areas of New Jersey differ greatly in their geographic, demographic and population characteristics. For instance, there is a designation in Bridgeton, in Cumberland County in the southern part of the state, that is based largely on the migrant population. This population has very specific medical needs and has historically experienced limited accessibility problems both in terms of geographics and language barriers. In contrast we have a designation in a section of New Jersey's capital, Trenton, which is based solely on Medicaid-eligible population.

I thought it would be interesting to take an in-depth look at two designations in New Jersey that are very different from each other. The first, the city of Newark, is an urban area with a population of 318,000 people. It is the largest city in New Jersey spanning roughly 24 square miles and the most densely populated area of the state with 13,177 people per square mile. Like many of the older northeastern cities, Newark has experienced urban decline. More than 82 percent of the residential structures in the city were built prior to 1960. Most of the housing in Newark, approximately 80 percent, is leased. Newark has an interesting historical background in terms of its designations. The city of Newark is three separate designations -- north, south and central. This came about following the influx of monies in the early '70s through the model cities program. When asked to identify the priority needs, the community leaders requested that funds be sent for construction of health care centers that would provide primary care services to the residents of Newark. As such, three health centers in Newark were built.

Recognizing the potential impact of the then newly created Bureau of Health Professions, Newark submitted designation requests for the area surrounding the three health centers, as all of the facilities have qualified for the designation. South, central and north met the criteria established by the Federal government. As the areas were designated, health centers were then staffed with Federal doctors. Rational areas for the designations have not changed over the years. Most recent evaluations of the HMSA designated areas as published in the 1986 issue of the Federal Register indicates that Central Newark is designated in Level 1, North Newark, Level 3, South Newark, Level 1.

South Sussex is defined as Sussex County minus its most northwestern towns and designated as a level 4 primary care HMSA. Sussex County is one of New Jersey's northernmost counties, a largely rural area, as 50 percent of its 118,000 residents reside in rural areas. Almost 50 percent of the residences in existence have been built since 1960. Eighty-one percent of the housing units in the county are owner-occupied. The population density is 226 persons per square mile. It is very, very different from Newark. The total county of Sussex had originally been designated. However, in 1984 the Federal government, during its re-evaluation process, decided the three northernmost towns should be excluded as the residents of those towns were crossing over state boundaries getting their primary care services from New York. As such South Sussex was re-evaluated and granted a level 4 designation.

Right now New Jersey is undergoing a crisis with regards to the HMSA designation process. HSAs were always the forefront of this whole program. They are often the ones to initiate the actions, bring the information to the state as far as what areas needed to be designated. They have pretty much closed their doors or at least will be within the next few months. We do not know what will happen in the future as far as who will handle most of the HMSA designation process work. The state has always provided technical assistance but they have not committed to taking over all the work involved in designations.

MR. SALLADAY: Thank you, Justine. Any questions on New Jersey?

Thank you. Our next state speaker will be Dave Peterson from the frontier area of South Dakota.

MR. PETERSON: Depends which side of the river you are on. I would like to discuss the primary care situation in South Dakota and how we view rational service areas. We are trying to alleviate some of our shortages. I would like to talk first about the number of docs in South Dakota. We are not following the national trend in getting doctors in our rural areas. Over the last 40 years we have lost docs. There were many more towns with physicians in 1940 than in 1986. The trend of the migration has been towards the more urban areas in the state. I am sure in many areas of the country it would be called rural or frontier.

MR. LABREC: How has the population changed between those areas of the population?

MR. PETERSON: Our population is about the same. Although the rural areas lost population.

One community has 340 of the 1,000 doctors in the state. It is the only urban area in the state. We are trying to move some of the resources out to the rural areas to distribute more evenly. We have gained a lot of doctors in the last ten years. It has gone up considerably but they are tripping over each other in one community. That is the problem. Right now in what we call our rural areas we have 30 doctors per 100,000 population. You must realize that Sioux Falls and these urban areas serve a large number, but it is the population coming to the doctor, driving many miles. Viewing our physicians, where they are located and per population, we wanted to find out if this has an effect on the number of physicians in an area and if there is any relation to the amount of people to where you are living and their health status. Which followed a study that was done in Utah that examined lengths of life or life lost, areas of life lost, working areas of life lost, versus whether you live in urban or rural. We defined a frontier area to see if there is any difference. There is a common perception that rural areas are very healthy. We don't have pollution, crime. But when you look at health statistics it doesn't seem to follow that picture at all. When we are talking about the different types of areas we define urban as greater than a hundred per square mile; rural is six to 99 people per square mile and frontier is less than six per square mile.

On the next slide, the hatched areas are our frontier areas in the state, covering approximately 60 percent of the geographic area but only has 20 percent of the population. We have one urban center in Sioux Falls. Minnehaha County has about 120,000 people. There are a lot of excellent services in that community. They provide services across the whole state, medical and other. Another area of the state that has a lot of medical services is Pennington County. They have a large number of doctors. Maybe some of you have vacationed there. We encourage you to come and look. We need your money. There are good physicians there if you are ever in trouble.

Most of South Dakota's population lives in the rural areas -- forty percent. As far as doctors or health personnel, about nine percent, or 92 doctors, work or live in frontier areas. Ninety-two of our roughly 1,000 doctors are in those areas, which gives us about 67 per 100,000. In the rural we have 125 physicians per 100,000. In the urban we have 354 doctors in that one county. It is obvious why we cannot attract physicians to these communities as they are isolated. There are not enough people in some cases to have an effective practice. Also ancillary personnel are not available. Offices are just not available. It would cost a considerable amount of money to set up a practice. We have a need to provide these services. In the analysis of looking at the three different areas and looking at the death records in the state over the last ten years or so, we believe we found that out in the frontier area, we lost more productive years of life than any other area. It's three times as high as the urban areas. We have much more premature death, heart disease, accidents and infant death. That is the main three causes. Some of it is lifestyle. In farming, ranching and mining communities, accidents are going to occur more often than sitting in an office. Also in the wide open spaces there are traffic accidents. There isn't any services available or very readily available. Minnehaha County has two helicopters that go to every accident. They can get a very quick response. Their emergency medical physicians who get out into the west and north. There aren't any of those. There aren't any physicians out there. We lose people that would be saved in an urban area just because of medical technology. The average in the frontier is 48 years of life lost per thousand. In the urban areas it's 27 per thousand. The rural is 32. So it's almost double from urban to rural.

MR. GOSSERT: Did you cut off at age 65?

MR. PETERSON: Yes. Sixty-five was cut off. Anything up to 15 if you died before 15. It was 15 minus 65.

MR. GOSSERT: I believe the way you have done it, we would have followed that same example. Why that rationale I am not real sure. We just did it that way.

MR. PETERSON: Any other questions on it?

FROM THE FLOOR: I am sure you have examined the idea of physician's assistants or nurse practitioners?

MR. PETERSON: Correct, though you must have a physician advising.

FROM THE FLOOR: Can't you pass a law that says they don't have to be supervised?

MR. PETERSON: We do have physician's assistants. They probably have as much problem trying to live in these rural areas as the physicians do. I want to bring up some of the ideas that we are looking at. That is one of them, nurse practitioner. I will get to that in a few minutes.

I would like to address some of the questions or the concerns of the use rationale with regard to the HMSA designation and how we feel our state is properly distributed and how services can be delivered. We have a challenge that we feel these frontier areas should have adequate or as good medical services as the other counties, as the other parts of the country have. We have worked with the National Health Service Corps and with the HMSA designation process to try and determine rational service area where we can put physicians who will serve the population. If you look at the entire northwest quarter of the state, there is absolutely no way we can get a private practice doctor to go up there to practice. We would not even try because the doctor would starve to death. The only possibility is right on the North Dakota border. I believe we do have a doctor there.

MR. LABREC: Are those all geographic?

MR. PETERSON: It's all geographic.

Maybe I could give you an example of what we tried to do a year ago. We had some interesting debates with Phil and his office. It was our estimate that this was the best way to provide a service and to alleviate a shortage. This is what we had done.

First of all, before we do any HMSA request we consult with the local physicians, hospitals, nursing homes and local elected officials. All of the HMSA requests are already checked through the medical folks before they are sent in from our office. That is our first criteria. We don't do them anymore unless they are requested to have them done. We have a number of areas in the state that are short but because the doctor in the community states an objection, we do not do it. If the community does not want to be designated it would be useless to go through the process. If they want a designation we will try and submit it. Most often it is a local decision. We help them develop the rational service area and proceed with the data analysis for it.

The example was in the northwest corner of the state, in Harding County. It has about 1,700 people and has always been and always will be a number one shortage area in our estimation, if left as a whole county designation. We attempted to combine Harding County with Butte County as the citizens of Harding County are going to Butte County for services. We wanted to designate those two counties together and bring in a National Health Corps doctor to set up a satellite clinic in Buffalo, the county seat of Harding County and another in the eastern part of Butte County, in Belle Fourche. We felt it was rational although it did not meet the travel criteria. Buffalo is 70 miles from Belle Fourche but that is what their trade or service area is. They go to Belle Fourche for 95 percent of what they need. Either to Belle Fourche or to Bowling, North Dakota, a hundred miles further.

We were hoping to alleviate a shortage in the area by providing another doctor in a community that had a doctor to handle a bigger workload. The request was denied because of the size for one thing and also, below Butte County there is a county called Lawrence where a town, Spearfish, is reasonably close to Belle Fourche. Although the citizens of Harding County don't go to Spearfish they go to Rapid City or to Belle Fourche. As a result we didn't get the doctor. We got the eastern part of Butte County designated. Now we have two number 1s but no doctors. They are still going to Belle Fourche for services. According to the criteria the staff was right. I am saying the criteria should be changed to reflect the types of conditions that exist in these frontier areas. I am not criticizing Phil or anybody on the Federal staff because they followed the criteria and analyzed it rationally.

MR. LEE: Are you ready for a response on that?

MR. PETERSON: I have some more.

MR. LEE: Let me throw something in, then continue on. Our problem is that we are curbed by doing that, and we send National Health Service Corps people to part of the area that already has physicians. The citizens of the part of the area that is really underserved would have just as far to travel. It could be that the assignee would serve people already serviced and competing with the existing physicians already there. That is the basic reason. Also with that particular geography it was hard to see the reason for doing it that way. There have been other cases as in Nebraska where there is a central region and there is a lot of shortage counties around it. The only place to go is that central point. Why don't you let us draw a larger service area so we can collect enough people to make the ratio. In that case it's a bit easier to understand what they want. They still have the same kind of trouble in those cases that we did with yours. So, I am wondering if there is another way to handle it. What you are suggesting is to designate an area that doesn't have doctors.

MR. PETERSON: I don't think I am saying that. If you look at a rational service area it includes those two counties. If you include those two counties you are short. Those doctors not in a shortage area are short because they are serving both counties. We are trying to put the two service areas together to reflect what is actually happening. They are still serving those people. They are still short.

MR. LEE: People will drive longer than 30 minutes to get to care because they must. When they get there they don't have to wait for three hours or have a doctor that is overloaded.

MR. PETERSON: As I mentioned the plan was to bring a satellite clinic to the two shortage areas already designated. There were many clinics set up in those communities. Especially when they get most of their services in Belle Fourche and would bypass that doctor. If they bring in a National

Health Service Corps doctor for two years to establish a practice to get people coming and leaving, it would not benefit the population either. We are looking at it as a way to deliver the services. We are saying that the criteria should be changed to fit the actual conditions in some of these frontier areas. Get enough people to reflect the trade area, the actual pattern of use that already exists.

MR. LEE: It's a frontier area. You can, say, allow for traffic.

MR. PETERSON: That would be one way to approach it. It reflects what is happening. You do not get anywhere in 30 minutes up there. Even if they are there they could be in the county seat and they are really not anywhere. For some folks 30 minutes is all it takes to go that 70 miles. It's in the wide open. Law enforcement usually isn't around.

MR. SALLADAY: I am looking at the frontier area map and I see both Butte and Harding County do have less than six per square mile population. I think in this particular case when we look at two counties together it seemed like a questionable effort to stretch to create a Level IV degree of shortage since we have two Level I degree of shortages now. I realize that in terms of outcome that didn't work for you in this particular case. But we have in a number of counties or reviews in South Dakota tried to extend a bit in terms of what comprised a rational service area. We have stretched a bit beyond the 30 minutes in a number of cases. I think with this one at 70 miles it seemed a bit too far. Now, if they change the official speed limit on rural interstate highways that might affect how far you can go.

MR. LEE: I am not concerned about defending what we did in this particular case but what would be a solution for this problem.

MR. PETERSON: We are doing a primary care plan. We are working with quite a few providers in the state right now to try to deal with this issue of what to do to try to help our more rural residents receive service and be aware of what their needs are or what they can have. We really don't know either. Physicians assistants, or maybe to get a doctor to Belle Fourche and Spearfish, what we call more urban areas. The city itself is a pretty good size. It is very hard to recruit doctors.

MR. LEE: Can I ask you a question? I noticed that you made the map very carefully. Have you found the degree-of-shortage to be a sensible discriminate between those shortage areas?

MR. PETERSON: I guess I am not following you.

MR. LEE: The one that comes out in applying our criteria is shortage "01." Worse than "03", much worse than an "04?"

MR. PETERSON: Most of the HMSAs don't have full-time doctors except the "04s". The ones that rate an "04" are the ones able to get the doctors because it probably has a hospital and a clinic. The NHSC doctor or the recruit can come in and establish practice. The lower left hand corner is an example. That wasn't designated but as we were scrambling to keep a doctor in Northsack we went from the top to the bottom. We were able to designate that area and get a doctor in. They are just barely short. It is really not a shortage area anymore. We have a doctor there and he is going to stay.

MR. LEE: In the particular case you used the example Belle Fourche where there is a hospital; is that correct?

MR. PETERSON: There is a hospital and established clinics there, correct.

MR. LEE: That is information we have not traditionally insisted upon. For instance, if you wrote in from South Dakota and gave us a map that does not show where the hospitals were and maybe assumed that all the Feds know where all the hospitals are, we don't.

MR. PETERSON: I am told you know everything else.

MR. LEE: We do. It's all we can do so far just to locate where the primary care physicians are. When we get into urban area designations we sometimes consider a hospital's ambulatory outpatient clinic service area. It seems in frontier areas that is a key because there might be a very good reason to expand a service area in a frontier area with a hospital resource. Without that hospital resource you can't operate at all. We could ask people requesting designation of a larger service area in a frontier region to give us the distribution of hospitals.

Does anybody have any comments?

MR. MCGINNIS: I am from the state of Oregon. We have similar sorts of numbers with frontier counties and health status situation between urban and rural population. I think it's important for you to note that when you are working with rural communities and trying to work with policymakers on how to alleviate those problems, there is a question in the health status materials versus intensity and magnitude. Your health status indicator in the rural areas will be more intense but the magnitude of the problems are greater in the urban areas in regards to how many babies will be in an infant mortality rate. It's important to distinguish that when you are trying to make policies and in trying to get your state to do something about the frontier areas.

I have heard mentioned this morning a couple of times population bases to support a practice. If you are doing your job in setting your proper billing reflecting out an appropriate rate, we have many communities of less than 2,000 or so in our state that support clinics. Generally we think that a nurse practitioner or physicians assistant can practice independently. In the state of Oregon it requires a thousand people to make a practice succeed, or 80 to 90 percent of what a family practitioner could provide. Which is a lot of basic health care a frontier community would need. There are a few National Health Service Corps nurse practitioners who are available.

MR. PETERSON: I don't feel they are as reluctant to travel to these areas as the docs are. I understand that Oregon is rural. But I would state that a doctor would look at Oregon as being an attractive place to go practice. However, the poverty level and the problems in many of these areas of South Dakota make it not an attractive place to go.

MR. LEE: I am sorry that Marva Jackson isn't here today. I am thinking in terms of a rural health initiative consortium strategy that I know that primary care folks have designed in part to deal with this kind of problem. Linked together in a number of frontier or rural areas so that you can have a National Health Service Corps physician among the different areas. I know they also developed it around certain centers and hospitals. They look at that information. This is another example of coordination we need to improve. You could share somebody with another area.

MR. DOWNEY: We have a lot of frontier areas in the state of Nevada. Outside of Reno and Las Vegas is a big nothing. It's fine to talk about the consortium and getting a physician to be shared. We are talking large geographic areas. It really isn't practical to have a doctor on the road going three, four hours a day from clinic to clinic. We had it on a smaller scale project in Arizona where we had a National Health Service Corps doctor servO ing rural communities. It has worked out well but it has a lot to do with the individuals who happen to have this. I really would like to see as much thought and discussion given to these frontier areas because it's easy to shrug them off by saying they can get together and share resources among themselves. The reality is that the areas are just too great. We really would be looking for an approach. People from rural areas have to go to those communities to do their grocery shopping anyway. So going there for medical care is no big deal. My message is please do give some serious thought to those frontier areas.

MS. SIRMANS: Is there a Federal definition for frontier?

MR. LEE: Less than six that was a definition that we understand was developed in connection with the rural programs. It's in there because it adopted something very close to those guidelines. What is in that newsletter is a description of the characteristics. Service population 6 per square mile is frontier. Six to 99 is rural. A 100 or more, urban contrasted to areas where they think rural is anything less than 50,000. It reinforces what you are saying. You just can't talk similarities because there are no similarities.

We sometimes lapsed into a definition that simply says areas have been defined by the Census Bureau's standard metropolitan statistical areas. That doesn't give you a hell of a lot of discrimination.

Did you have another question?

MS. PHILLIPS: I wanted to pursue what I perceived from your part was an exploration of other ways to look. If you want those hospitals maybe you also need some discussion of size and use. In South Dakota, 6, 8, or 12 bed hospitals are the norm, even though they might be basically empty of patients. I don't know how you look at that compared to other areas in terms of what is really happening there. What constitutes the service patterns?

MR. STAMBLER: That's the department's initiative on examining the possible closing of rural hospitals. We fear a number of them may close. We have been providing quite a bit of data to the Secretary's task force on this. It's a major concern.

We have also been concerned about the presence of a hospital as an incentive for doctors to go there. It may be a shortage area simply because it doesn't have a hospital. Others with hospitals, even very small hospitals, may have as much of a shortage there.

MR. LEE: It has to do with getting a critical mass of population on the one hand and resources on the other hand. It just helps make the case for these large areas a frontier area if it has a hospital.

MR. STAMBLER: It may make a case for changing the criteria. In the current framework of the criteria it really wouldn't help very much.

MR. LEE: We are not talking about the current framework; we are talking about what we should do.

MR. STAMBLER: I think that is something we have been talking about among ourselves a bit.

MR. LEE: I think this discussion has been very helpful. We can continue to discuss this issue in the small group meetings this afternoon as well as in the events of tomorrow and the day after. Perhaps as we talk more about it, we can develop some more concrete recommendations for Friday morning. At this point I think it's time to cut this section off and move into the small groups.

(Whereupon, at 2:10 p.m. the meeting adjourned.)

FEDERAL PROGRAMS RELATED TO HMSA DESIGNATION

Howard V. Stambler
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MR. STAMBLER: There are a few things I wanted to mention before we get into some of these programs. There is a very clear line of demarcation between the program that we are here to discuss, which is the HMSA designation program and the National Health Service Corps primary care and other programs. Our health manpower shortage area is basically an analytical approach to identifying areas based on statistics, published criteria and objective analysis. The Corps and the HPOL have the responsibility to place physicians and to view a variety of things within HMSAs to ensure that placements are appropriate, proper and to do the job in a way that is very different than ours. I think we tried to make this clear. There is often confusion that shortage areas are designated by the Corps even in the congressional correspondence we get. Part of the reason for that is the authority for designating HMSAs is in the National Health Service Corps legislation.

Nevertheless, we work very closely together in dealing not only with designations but in identifying and getting information on where Corps people are. We also do quite a bit of analysis in the other side of ODAM that is used by the Corps or the Bureau of Health Care Delivery and Assistance. We work together so that questions get answered.

One question raised earlier deals with how long HMSAs will be designated now that Corps scholarships are being reduced. Is there going to be a need for it and will we be in business? It will be there for a long time, the need to designate. It will become even harder and more inportant in the future because we don't want to misidentify areas. When you have 1,000 or 1,500 doctors coming out and 100 or so dentists, a mistake in the HMSA designation or in a placement is not a major disaster. With a small number of people, this means that the original designation has got to be better. We have to separate more cleanly those areas that are adequately served from those that really need the few Corps people.

The HPOL also will need to make more difficult decisions because there are not enough people available to meet everyone's needs. Thus, we will be in business not only for the designation for the few Corps scholars but for the potential changes in areas. Areas are going to be designated because even when the HPOL Corps scholarships are eliminated, the Corps will be providing personnel through a number of means, whether through volunteers or through some mechanism. Again, unless something changes radically there will have to be health manpower shortage area designation program. We don't look on this as temporary. The Corps program is not being phased out despite the possible elimination of scholarships.

Right now I would just like to mention a couple of HMSA related programs. In a sense, this is to give you some idea that the shortage area designations are aimed very heavily at the Corps and their uses, but at the same time are used in a number of other programs. The Bureau itself, utilized HMSAs and a couple of other agencies and a number of states depend on the HMSA designations and/or the criteria. The first one is unnecessary to mention, which again is the National Health Service Corps that you will hear about shortly from Irma. We do have a number of others, however. One of those is the nurse practitioner traineeship program, which provides funds and scholarships to nurse practitioners and nurse midwives who are from and/or agree to serve in shortage areas. This is a fairly new program funded only about six months ago. Nobody will be coming out of that program for about a year but we have made arrangements to try to deal with that.

Another similar type of program is one that deals with family medicine both in the graduate and in the undergraduate sense. These are separate programs: predoctoral and graduate. Funding preference is given to those programs that will provide substantial family medicine training and the primary care HMSAs.

Then there is general internal medicine and pediatrics program that is funded to plan, develop and operate approved residency programs in those fields. The funding preference again is given to those providing substantial training opportunities in primary care HMSAs. The language is generally vague enough that it can be dealt with and can give flexibility both to the schools applying and to the people who are providing the critiques and reviews of the proposals. The physician assistants program is another one. One of the newer programs just going into effect is the geriatric center program set up to deal with geriatric training and education to improve the provision of services.

One other major program that is closely related to some of the things going on in your areas are the Area Health Education Centers (AHECs), which are centers set up to take the education and training out of the basic medical school environment to remote sites. The process creates a consortium between schools, providers, hospitals and the community. They can be remote areas and can be rural or urban as well. There the preference is given to centers in HMSA.

There are two other programs that have this kind of reference. The health education assistance loan is the billion dollar loan program that the Bureau operates to provide funds at pretty much market rates on an "as you please" kind of basis to students in the health profession. Within the program there is a loan repayment provision and there are some discussions now that would lean more toward providing funds to pay off loans for service in a health manpower shortage area in a particular profession in a variety of locations where the Secretary deems it appropriate.

There are also proposals for a new, more general loan repayment program. This would take place a year before the individual is needed within a particular location or health profession. At that time agreements would be made with an individuals who would get their commerical loans repaid in return for service.

The nursing student loan programs and health professions student loan programs provide funds directly to schools which then provide them to persons with financial need in nursing, medicine and other diciplines. This also has a loan repayment characteristic. We did this for awhile, where only government loans were repaid. At that time the Bureau's loans were only $1,000 to $2,000. It wasn't worth putting in a year some place to get a $1,000 or $2,000 loan repaid. In the proposed program, the discussion has been to pay commercial loans and provide loan repayment provisions to permit the Secretary to identify where an individual should go.

One relatively old/new program using the HMSA designations, is the Federal Employees Health Benefits Program. We received a letter from a Congressman in Oklahoma. "Have you taken Oklahoma off the list of medically underserved areas?" Well, it just so happens that Federal Employees Health Benefits Program consists of probably several hundred health insurance programs, etc., including Blue Cross-Blue Shield. As it turned out, with some investigation we learned that FEHB identifies medically underserved areas in states using the HMSA data. We supply them data. They qualify for repayment. If an insurance company decides to get out of the program, those medically underserved states can still maintain the same price and quality. I am not clear on this. I can read you the paragraph.

Do you know any more about this, Dick? I am unclear about the benefits. It's very clear that HMSA designation is used mechanically to identify a certain number of the states -- only three states. What they do is they use the statistics on the underserved population in HMSAs.

MR. LEE: If 20 percent or more of the population is in a primary care HMSA, they then declare that a medically underserved state. Since certain professionals can be deducted from Federal Employee Health Benefits, normally that would not be. That includes chiropractors, for instance, but I am not certain it includes nurse practitioners.

MR. STAMBLER: Most of the health benefit programs don't include nurse practitioners. It makes our job in many respects more important, because the continuing use of the HMSA designations for these programs is important. That is why I think it is important for us to relate to each other in ways that can improve the process, the designations and the criteria, if possible -- to identify in a changing medical scene those areas and those programs that need the manpower more so than other areas. We have talked quite a bit about frontier areas and we have talked quite a bit about a number of other things. I want to keep emphasizing that we're not here just to talk with you. We are here to get something back from you and to obtain some recommendations on where we go in the next year, two or three.

Do you have any question on this before we move on?

MS. SIRMANS: One of the problems that we have is trying to evaluate the time that we spend doing HMSA designations and the HPOL list; we do have a contract. We are working on other things like practitioner placements. You mentioned several programs that we are not really involved in. Is there some way we can take advantage of these, so that it makes the actual time spent with designations easier to validate?

MR. STAMBLER: Two answers to that. First, your job is a very difficult one. We have never been able to have the work and time spent on the designations paid for or included in any particular kind of contract effort. This means that we literally have had to call upon volunteers. Two years ago, a bill was put in by Senator Kennedy that provided funds for the development of data needed for health manpower shortage designation, but it never was passed into law.

I spoke with Dr. Lassek, the Regional Health Administrator in Region III the other day, and the Bureau is going to try to provide closer ties between these programs with printouts of where the HMSAs are, which will then be used in the regions as they please. The Bureau suffers from a lack of communication with other PHS programs. But you will get more information on the programs and a listing of the programs, the numbers of persons involved in each and the location of the programs.

Dick suggested a small brochure, which we will be glad to put together. We were discussing a bit broader effort to provide specific information you can use in going after some of these people who have been trained under the Bureau's programs.

We had a question on labor certifications, which we will be discussing later. Any other questions?

MR. LEE: We have with us Irma Honda from Region IX. We asked the Bureau of Health Care Delivery Assistance for a representative and they felt that it was not necessary to send someone from the central office, so they sent Irma to tell us the regional office perspective.

NATIONAL HEALTH SERVICE CORPS HPOL DEVELOPMENT; PLACEMENT POLICIES AND PRIORITIES

Irma Honda
Chief, California Operations, NHSC

MS. HONDA: Good morning. Before I start, I would like to say that I will limit the number of acronyms I use. Let me tell you which ones will be used: NHSC, National Health Service Corps; HMSA, you all understand; HPOL, stands for Health Manpower Shortage Placement Opportunity List. That is the list the National Health Service Corps uses in placing scholarship-obligated physicians throughout the country; BHCDA, Bureau of Health Service Delivery Assistance; and CHC is community health centers.

The NHSC is the principal program that uses health manpower shortage area designations. The mission of the NHSC is to provide health manpower resources to areas, populations and facilities of greatest need that cannot otherwise recruit and retain health care providers. The program works in this way.

The National Health Service Corps scholarship program provides scholarships to students while they are in medical school in return for which the students agree to provide primary health care service in a health manpower shortage area for a minimum of two years. The length of obligation is determined by the number of years of support that he or she received. They must serve one year for each year of support received. So the maximum number is four years, the minimum number is two years. The scholarship obligation is discharged by entering into a full-time clinical practice of their profession in a health manpower shortage area. This can be done either as a federally employed provider or a non-Federal health care provider. They must, while they are serving their obligation, provide services to everybody regardless of ability or inability to pay. They must accept part B Medicare assignments as payment in full. They must enter into an agreement with the state agency for provisions of services to Medicaid eligibles. For those individuals who cannot pay the full cost of services they must provide a discount or what is commonly referred to as a sliding fee scale.

How does a community get a National Health Service Corps scholarship recipient to serve the community? The first criterion is it must be a health manpower shortage area. There are many, many more health manpower shortage areas than there are scholarship recipients available to fill them. This was true even when we had the peak number of scholarship recipients available for placement. So the program has to target the resources we have to those communities that we feel have the greatest need. That is represented by the HPOL. The HPOL was first used in the placement cycle of 1983. It is based on language from congressional hearings that very clearly state that the Secretary of Health and Human Services has to target National Health Service Corps resources to those areas of greatest need. The HPOL is a means of doing that.

The way that the NHSC develops the HPOL is quite complicated and involves many individuals and many organizations. We are talking about physicians because the scholarship pipeline has very few, if any, other health care professionals. We start about 15 to 18 months before the group of physicians will be available for placement. Today we are beginning to develop the HPOL for the 1988 cycle for people available for placement around July of 1988.

We begin by looking at the health manpower shortage areas, especially those in need as indicated either by their being designated as 1, greatest need, or as having a high threshold, the number of physicians needed to remove that HMSA designation. For instance, in some areas in Los Angeles we have health manpower shortage areas with thresholds of upwards of 20. In other words, more than 20 physicians would be needed to move into that area before it will no longer qualify as a health manpower shortage area. We start looking at the HMSAs, those that have the high needs in terms of numbers. We look at those communities where we have National Health Service Corps providers that we know will be completing their obligation and plan to move on, will not be staying. Throughout the year, we also get requests from communities or health care organizations for National Health Service Corps personnel.

In cooperation with state contractors or cooperative agreement agencies, we then identify those areas that would represent the highest priority for the year. NHSC began contracting with states to assist us in the implementation of the National Health Service Corps. For instance, in Region IX at one time we had contracts with four of the states: Nevada, Arizona, California and Hawaii. Currently we don't have a contract with California but other states either have a contract or a cooperative agreement. The cooperative agreement is different from the contract in that it is not geared solely to NHSC activities. The cooperative agreement agency works on the overall issue of primary care in their state and develops priorities. Some of the resources they use in trying to alleviate need are NHSC physicians but they also work with state and primary care associations, community health centers, migrant health centers to develop a state primary care plan.

The state contractors or the state cooperative agreement agencies provide the regional offices with input on priorities for placement. These are gathered, analyzed and submitted to our central office in Rockville, which has the responsibility for allocating the resources on a national basis. They use the HMSA data base to tell us the need in each state and region. Regions with the highest need will get the highest number. Region IX consists of the states of Arizona, Nevada, California, Hawaii, and the Pacific basin. It's a large region geographically and population-wise. There are ten regions nationally. We usually get less than one-tenth of the number of scholarship recipients available because there are other regions that have states in much greater need than in this region. For instance, Region IV, the southeast region, probably has the greatest need for health manpower resources.

Once the HPOL is determined, there is one HPOL for each primary care specialty. There is one for family medicine, internal medicine, pediatrics, OB/GYN, and one for emergency medicine. That's the other specialty that we place.

The HPOL has one vacancy and no more for every scholarship recipient available for placement. Once the HPOL is developed, it is sent to every scholarship recipient available for placement in any year and during a period of time, that individual has the opportunity to select from that list any vacancy that appeals to him or her. We still assist in covering the costs of any trip for them to visit one or more sites to interview. The individual scholarship recipient and the community or organization that has the vacancy will come to an agreement. They each have to agree in order for the match to take place. In those instances where the individuals do not voluntarily select a placement site, those individuals will be given specific site assignments at the end of the placement cycle to any vacancies left over. They will be given a specific site assignment regardless of their own personal preferences. In the past few years the number of site specific assignments has been very low and in this region we virtually have not had any. All of our vacancies have been filled during the period when people had the greatest choice. An advantage of working in a region that is relatively attractive.

The placements are, as I said, either as Federal employees or as non-Federal employees. Since 1982 the emphasis on non-Federal employees has increased significantly to the point where Federal placements are the exception rather than the rule. The reasons for this are many. First, in 1979 the legislation authorized National Health Service Corps recipients to fulfill their scholarship obligation by what is called the private practice option. Secondly, maybe even more significantly, Federal employment offers relatively low salaries. Physicians are brought in as either officers of the Public Health Service Commission Corps or Federal Civil Service employees. The salaries of these Federal individuals runs around $36,000 to $44,000 a year, significantly less than most physicians are willing to accept. The other principal reason for having the emphasis on non-Federal placement is the somewhat difficult situation that was sometimes experienced in some communities where for all intent and purposes the Corps physician was an employee of that site and worked at that site. However, that site did not pay his or her salary. The site sometimes felt that they did not have adequate or sufficient supervisory control over those individuals and would say we are not controlling the paycheck. It has worked out much better to have the National Health Service Corps physician serving as employees, direct employees, of the entities, where they are working. Over half of these physicians are working at community health centers, CHCs, that are funded by BHCDA. They are employees of those entities and subject to their personnel policies. The recipients working at community health centers are working under the private practice assignment. They are members of the National Health Service Corps but they are not Federal employees. Were they to elect to come into Federal service at the end of their scholarship obligation they would receive credit for the time they served as private practice assignment employees for retirement purposes in the Commission Corps. If they served three years as a private practice assignment physician and came into Federal service they would get three years for retirement purposes.

Now, all this is fine and good but you are aware that National Health Service Corps scholarship program is on the wane, to say the least.

The largest number of scholarships were granted during the period 1976 to 1979. Because of the time it takes for training to be completed, the greatest number of health professionals available for placement were available in the years 1983 to 1985. We are now definitely on the downswing. Since 1981, the number of scholarships awarded had virtually dwindled to none. Just for comparison, in 1977, 2,092 new awards were granted. In 1978, 2,380. In 1986, 35 new scholarships were awarded. So the pipeline is definitely drying up, in terms of those available for placement. And these are just rough figures. The exact numbers are always difficult to pin down. We peaked in 1984 with approximately 1600 scholarship obligated health professionals available for placement. The 1988 cycle, that is those who will be available for placement in 1988, was around 400.

In addition to the National Health Service Corps, we also use scholarship obligated physicians in the Indian Health Service. So because of the needs of the Indian Health Service we are thinking maybe 100 of those physicians will be allocated to the Indian Health Service leaving approximately 300 for the National Health Service Corps program to be allocated nationally. The numbers are not positive in terms of scholarship obligated health personnel available to HMSAs.

The question was asked earlier to justify the time spent on HMSA and on developing the HPOL. Well, we have been aware for some time that the pipeline was going to dry up. We have been aware for some time that new scholarships were not being awarded. So in the past year the National Health Service Corps has started an intensive effort at recruiting physicians who do not have an obligation to work in health manpower shortage areas, to serve underserved populations. We have awarded a national contract and that contractor is advertising in professional journals. They have contacted all the primary care residency programs and informed them about our interest in recruiting primary care physicians to serve underserved populations. A letter has been sent to every third-year resident in family medicine, internal medicine and pediatrics informing them about the opportunities in underserved areas.

Regional offices are developing their own recruitment programs. In our region we have personally contacted all the family practice residencies. We have made presentations to over half of them. We are attending meetings of family practice and other primary care specialties that are being held thoughout the state generally informing them about opportunities in health manpower shortage areas. We call this a volunteer recruitment effort, which is misleading. We are not asking them to volunteer their services for no pay. We are asking them to think about serving the underserved populations. Interestingly, the number of people who we have been able to match to communities under this program so far has not been that significant. It's less than 100. But we believe that with time this will improve. Many people thought there was no National Health Service Corps anymore, that it was going to die, that there were not going to be any efforts to recruit them to serve underserved populations. We have met many individuals truly committed to serving underserved populations. Most of the placements of those individuals have been in areas we considered hard to fill. They are rural, isolated communities as opposed to vacancies in urban areas that we thought would be quickly filled. The individuals being referred to our region for placements are much more interested in rural placements than urban placements.

In addition to the volunteer recruitment program, the National Health Service Corps legislation has been up for renewal for several years. Legislation has been passed and been vetoed. We have been on a continuing resolution for several years. At the end of February, Congressman Waxman from California held hearings on reauthorization of the National Health Service Corps. The indications are that there is strong support in Congress for continuation of the National Health Service Corps program. The question is what form it will take. It will definitely be smaller in size than it was in the past. The days of awarding 3,000 or more new scholarships a year are long gone.

If there is a new scholarship program, the numbers will be limited. The numbers that have been bandied about are between 300 and 400 per year.

The second component that is being discussed is a loan forgiveness program. The form it takes is unknown. There is definite interest in having a program that will allow physicians, who have significant debts because of financing their medical education through loans, to have parts of their loans waived in return for serving in a health manpower shortage area. The loan forgiveness program is very important because it's the only way, frankly, that we can have a pool of applicants to draw from fairly quickly. If a scholarship program is reauthorized it will still be five, six years down the road before there are any physicians available for placement. With a loan forgiveness program, we can start as soon as it is authorized and regulations are established as to how it is to be implemented. It's important that if there is such a program that it be developed quickly because the number of scholarship obligated physicians who will be completing their obligation starting next year, 1988, are much greater than the number we will have available for placement. So we won't even be able to replace the ones who leave if we wanted to replace them.

MS. CAGEN: Could you comment on the volunteer placement program? Do you offer any financial assistance to health centers to pay the salaries of these physicians?

MS. HONDA: If they are at federally-funded community health centers, these physicians are included in the ongoing budget. But for placements at other than CHCs we do not have any authority to offer financial assistance.

MS. SIRMANS: Can you say something about the amount of scholarship money involved and penalty for payback?

MS. HONDA: The program awarded scholarships that paid full tuition and a small stipend. Most of the National Health Service Corps scholars attended private medical schools and, depending on what their tuition was, that is the amount that was granted. If they don't serve their obligation in a health manpower shortage area they can pay back their obligation monetarily at three times the amount received plus interest. That provision was entered into the law after the first scholarship program was enacted, because the first scholarship program didn't have that provision. It was seen by many as a low interest loan to finance their education. All they had to do was pay back what they got, which wasn't difficult. The triple payback was enacted as a result of lessons learned. The amount, three times plus interest, is rarely less than $100,000. It is due one year from the time they are supposed to begin to serve their obligation.

MR. MCGINNIS: I understand that a quarter or more of the available scholarships this year are psychiatrists. Does the scholar have the choice of specialty? We have been overloaded with internal medicine physicians. I wonder how the control of specialties is handled on the scholarship side.

MS. HONDA: The only control is the types of residency programs authorized. Psychiatry is one, internal medicine, family medicine, emergency, or pediatricians. There is no way that the scholarship program can force an individual to go into a family practice residency if they don't want to. The result is that the needs do not necessarily coincide with the availability.

Sometimes we are forced to make less than ideal placements. I think somebody mentioned an internal medicine physician in a very rural community without access to a hospital. That is not a profile for success.

MR. LABREC: On the volunteer program, are you going to plan to do something as fair as clarification? I have seen several things since its inception. First, for instance, the notification we got on the program said it was preferred that we select sites on the HPOL. It wasn't necessary. So I included additional sites, rural hospitals that are not HMSA designated. They came back and I was told they had to be HMSAs. Also with travel originally there was travel money I was told. If there was a confirmation between a site and a provider to do an interview I had to have this in writing and the regional office would assist with travel to the site. I told the provider that. The next day he found out the money was frozen.

MS. HONDA: First, there is very little in writing regarding policy on the volunteer program, which is both good and bad, depending on your viewpoint. What we have done in this region is taken the absence of codification to give it the greatest flexibility possible. That means that technically the National Health Service Corps should address needs in health manpower shortage areas. There are some community health centers that are not in health manpower shortage areas but are in medically underserved areas. I don't want to get into the difference but there are two different designations. To qualify for CHC funding you must be in a medically underserved area, an MUA. That is different from a health manpower shortage area. The criteria are different. Not all community health centers have HMSA designation but they do have MUA. At least the perspective in this region is they are serving underserved population and, therefore, we feel that we should be working with them with the volunteer program.

Off the record, if there is an area that we know would otherwise qualify as the HMSA but hasn't gone through the process, we will invest some of our resources in it. The issue of travel is the good old standby on a case-by-case basis. We would not authorize travel to a non-HMSA. We would probably not authorize travel to an area if there were some resources in the community to provide for that travel.

MS. GLIDDEN: If the Corps picks up the loan forgiveness program through the residencies, will they select specialities before they do the loan forgiveness?

MS. HONDA: This is all very tentative. It is a nebulous phase because there is no legislation yet. It's not being proposed by the administration; it's being proposed by Congress. My guess would be that any loan forgiveness or any future scholarship program would have controls built in it to try to make sure that the types of providers who are available met the needs in the communities.

MS. CAGEN: I understand that some 2,000 National Health Service Corps physicians are in default, that there is a lawsuit pending. Maybe you could talk about that a little if you think it's appropriate. Also I understand that sometime in the next month there is going to be a preliminary ruling whereby, if the physicians win, all the placements in this coming year are off. The result -- not to go where they have been assigned and go somewhere else. What are the implications for health centers that haven't been able to get a physician?

MS. HONDA: The second question first. There is a class action suit filed against the National Health Service Corps, by an organization called an ANHSCSR. That's the Association of National Health Service Corps Scholarship Recipients. As part of that suit, they asked for an injunction to stop the current National Health Service Corps cycle.

One of the main points in the ANHSCSR suit is the use of the HPOL. They are challenging the use of the HPOL. If the injunction is granted, there is the possibility that the HPOL would be thrown out the window and those communities that are currently on the HPOL that do not have matches would not be guaranteed of having a body to fill their vacancy. Possibly also some of the matches that have been made already could be dissolved and chaos would ensue to say the least. The decision on the preliminary injunction, we understand, will be made sometime at the end of this week or next week. We are keeping our fingers crossed.

In addition, let me answer the first question about the number of scholarship obligated physicians who are in default. The numbers have been bandied about all over the place. I have a copy of Dr. Sundwall's testimony on the National Health Service Corps reauthorization hearing. In it he says that currently there are approximately 763 scholarship recipients who are eligible to serve whose debts are delinquent and they are not repaying those debts. We are working with them to find solutions. There are 500 additional scholarship recipients who were declared in default and who have already worked out arrangements under a Forebearance Agreement. The Public Health Service has agreed to forebear collecting the debt they owe if those individuals agree to serve. Those individuals are being placed throughout the country.

Incidentally, that 763 is potentially an additional pool to draw from because if we get them to agree to sign a Forebearance Agreement, they will be serving their obligation in a health manpower shortage area. The National Health Service Corps position definitely is that we prefer to have them serve. We gain nothing by collecting the money that they owe.

MS. SIRMANS: Will this affect the 1987 placements?

MS. HONDA: Yes, they are targeted at this year's placement cycle.

MR. LEE: On that temporary restraining order, do they want everything restrained or just the placements?

MS. HONDA: It would affect the entire HPOL cycle.

MR. MCGINNIS: Maybe Howard or Dick knows if there is a National Health Service Corps physician serving in an area they consider Federal FTE counts. I know one area where if the matter comes up the physician would be there. I am not sure we want him. He was not placed there under the process.

MR. LEE: If he hasn't been placed there under the process, then he is not serving there as a member of the National Health Service Corps. The only people who are not counted are those who are either federally salaried or are official National Health Service Corps placements because they have a scholarship obligation and they are fulfilling it there. If they have a scholarship obligation and haven't been assigned there, theoretically they are supposed to be counted.

MS. HONDA: One additional comment on the National Health Service Corps physicians. Many of you have already been involved or will be involved with an individual who is determined to serve his or her scholarship obligation in a specific community, who will come to you for assistance in getting the area designated as a HMSA. The National Health Service Corps placement policy does not allow us to tailor or make vacancies for individuals. We look at communities in need. Our priorities are based on the need in communities as opposed to the need of individuals to be in specific communities. So the bottom line, I guess, is that it's possible that an individual can get an area designated as a health manpower shortage area, but that doesn't guarantee it will be on the HPOL or if it does get on the HPOL that individual will be going there.

MR. LEE: On that point, this does create a problem because somebody comes in and wants designation. The designation process is open to all commerce. Any agency or individual can make a request. If the person has a personal interest in getting the area designated he still could legitimately make a request designation. We go through the process and we determine the shortage area under the criteria maybe it would turn out to be a Group One or Group Two, then we get out of it okay. But it is then up to the community to request placement to the regional office. My question is: are you able to put on the blinders and look at this area alongside all the other areas and make a decision based on the need of this area as compared to others and not throw it out because you know there is somebody who really wants to go there? In other words, it seems people should not be allowed to choose their own sites from scratch, at the elimination of others. But there should be no reason why a HMSA site can't compete.

MS. HONDA: We have one specific example this year of that happening. A scholarship recipient got an area designated because he wanted to serve his obligation there. The data presented in the designation convinced us of a definite need and that the community had been unsuccessful in the past in recruiting. We put it on the HPOL. That individual was not selected.

MS. GLIDDEN: Are we going to be preparing HPOLs other than primary care and psychiatric?

MS. HONDA: Such as?

MS. GLIDDEN: Dentists, podiatrists.

MS. HONDA: There may be one podiatrist available. Dentists, no more than two or three. For all practical purposes for these professions, the pipeline has dried up. They take three or four years to get through their training. Since new scholarships haven't been awarded in over four years there just isn't a pool available anymore. There may be one or two individuals who may be under a Forebearance Agreement or who for some special circumstances were not able to complete their training on schedule.

MR. MCGINNIS: What about OB/GYN?

MS. HONDA: We consider that primary care. We understand that for 1988 a significant number of those available are going to be OB/GYN.

MS. SIRMANS: Has any particular guidance come out of the central office for the 1988?

MS. HONDA: Not yet. It's due before the end of this month.

MR. LEE: On the 1988 guidance and the HPOL issue, is it fair to say that HPOL would still be the device for placing obligated scholars and the HPOLs would be used with volunteers and kind of as a placement service and in order to get a HPOL you either have to be a HMSA or a MUA? That is, a community health center?

MS. HONDA: The MPOL, Medium Priority Placement Opportunity List, is the list we give to volunteers we are recruiting. It contains those sites that did not make it onto the HPOL. The MPOL represents the placement opportunity list for the non-obligated physicians we are recruiting.

There is a third list and there is a third activity that we are involved with which is small but there is also a CVL, the career vacancy list. The National Health Service Corps has a very small number, around 150 or less, of Career Public Health Officers and it's the policy of the Commission Corps that these individuals be mobile. It is the policy of the National Health Service Corps that their placement sites be changed every five years or so. The CVL is the list of vacancies from which the career officers can select placement. Under the CVL, career officers can be deployed to those areas that have no other way of getting health care or, depending on where that individual is in his or her career, to some larger systems of care that need somebody with experience to come and serve as senior medical officer or a medical director or that type of position.

MS. CAGEN: If a health center is on a CVL, what does that mean? What are their chances of getting a career health officer? Does that mean the person would be there for five years?

MS. HONDA: Three to five years, yes. The rotation of career officers is not voluntarily. The National Health Service Corps has definitely stated it's mandatory. We try to make it as palatable as possible by giving officers a list of all the vacancies and encouraging them to select the vacancy they would want to fill. We don't have any CVL vacancies in Region IX so I can't say. I understand that activity has been very slight in other regions in terms of career officers making arrangements for a rotation. If they have been at their site for more than five years, they will be moved. A site will be identified for them, so I would presume that if there is a career vacancy at a community health center and it has not been filled voluntarily, that someone -- we hope it doesn't come to that because it works much better when both the individual and the community want each other -- will fill it.

MS. PHILLIPS: Is there a list? I don't recall seeing it.

MS. HONDA: The list went directly to the career officers that are subject to rotation.

MS. PHILLIPS: You are talking about the MPOL and the HPOL?

MS. HONDA: There is no reason why the MPOL can't be distributed to states. We have the capacity now to print it out. It's computer based. We can print them out in the regional offices. If you are interested I would suggest getting in touch with your regional office.

MS. SIRMANS: How is the career vacancy list developed and do states have any input into the development of those lists?

MS. HONDA: There has just been one list. The process was like the development of any other vacancy list which would require getting input from all possible sources. Again, talk to your regional office about it.

FROM THE FLOOR: The list is not regularly updated?

MS. HONDA: There has just been one list so far.

MR. LEE: If there are no further questions, I would like to thank you. You handled a very complicated, sometimes difficult subject very well. We appreciate your being here.

If people have additional questions, Irma will be here. At this point we will take a fifteen minute break.

(Recess taken.)

MR. STAMBLER: We have three noteworthy and knowledgeable people to tell us about the range of activities, data and manpower issues that we in Washington and you at the state and local level do not often hear about. There is a tendency to miss many things that take place in the larger professional associations. AMA and ADA are critical players not only in HMSA activities but also in a variety of other kinds of activities whether on the policy level, the data level or on any level that deals with the health professions and health manpower services, etc. I am very pleased that we have three gentlemen to talk to you and show you slides.

I would like first to introduce Dr. DeWitt Baldwin, known as Bud to some of us. Bud is the Director of the Office of Education Research of the AMA.

PROFESSIONAL ASSOCIATION INVOLVEMENT IN HMSA PROCESS/DATA

DeWitt C. Baldwin, M.D.
Director, Office of Education Research
American Medical Association

Norbett W. Budde, Ph.D.
Director, Division of Survey and Data Resources
American Medical Association

Kent D. Nash, Ph.D.
Director, Bureau of Economic and Behavioral Research
American Dental Association

DR. BALDWIN: I am relatively new at this, having been at the AMA for a little over a year. So I probably am not the right person to talk about AMA policy, but I got elected! It reminds me of the prominent westerner who got a phone call one day from the White House. President Truman was on the line offering him a very prestigious job in Washington. Mustering his modesty, the man said, "Mr. President, I am deeply honored but I am sure there are many other people better qualified than I." President Truman's crusty reply was, "Yes, I know, I have already asked them."

Before joining the staff of the AMA, I was director of the Office of Rural Health at the University of Nevada for ten years. So I have been involved with the problems we are discussing at this meeting. I have sat in many such workshops and am very familiar with HMSAs, SHPDAs and the Bureau. My job here is to present some viewpoints on the HMSA process from the perspective of the AMA. I am happy to do so because there are some changes taking place that I believe will be useful to you.

The AMA has long been supportive of the HMSA concept and of the National Health Service Corps. We realize there will always be shortage areas, underserved areas -- areas to which physicians are not going to be attracted for a variety of reasons. We realize also that you have made a terrific effort to provide care to these areas through various devices. I spent some time trying to make successful matches between practitioners and communities while I was in Nevada. I found that it took a great deal of community development work, a skill which is insufficiently recognized and rewarded. You really have to work with a community to make such a match successful.

From this point of view the AMA does have a major concern with the process, so that existing health professionals in the community will be appropriately consulted. When I was on your side of the fence, I sometimes regarded local physicians as the enemy because they almost always tried to throw up roadblocks to the shortage designation process for one reason or another. I have come to a better understanding of this. I feel that it is worth trying to work with them, because they know the community and have made a commitment to it.

It is important to consider their views and consult with them, as they are rightfully concerned about the qualifications of the person coming into the community. Is he or she going to practice a quality of medicine that is appropriate? Is he or she going to be committed to the community or just serve their time and leave? They are also concerned about compatibility. When we were filling towns in eastern and southeastern Nevada, it was always much easier to place a western, Mormon candidate than a New Yorker. So the AMA would like to see local and national participation in the HMSA policies and decisions. This is not purely self protectionism. They want the community to be well served; they would like to see continuity, quality, compatibility and flexibility.

This last point reminds me of a town in Nevada that was an ideal placement town. It had no trouble attracting physicians and dentists. However, on the outskirts of that town was an Indian reservation which was not being well served. They had raised money to build their own clinic and to include a complete dental operatory. Having created this marvelous dental operatory, they needed a dentist. As predicted, the local dentists put up the usual protest, stating that they were already serving the community. They may have been willing, but it was not working. We went through some real gyrations to carve a HMSA shortage area so that the Indian community could get the service it needed. So I guess I am pleading for flexibility in certain unique and special situations. Certainly, a rule that fits urban New York will not necessarily fit rural Idaho. Flexibility and responsiveness are very important.

The immediate pressures on the AMA usually come from two sources: local physicians who complain about the disparity in fees charged by NHSC assignees and the NHSC assignees themselves. In the case of the former, it is important that the fee structure not put existing physicians at a disadvantage. As to the latter, unfortunately, there has been some evidence of what I have called the "crybaby phenomenon" in this process of assignment. People who do not want to serve distant or strange areas go crying to the AMA or to their Congressman. I am not at all sympathetic with this behavior. To me, service is service and an obligation is an obligation. I believe our laws and our values basically support this. However, there should be room for the kind of flexibility that tries to put people where they want to work and where they are most likely to stay. I recall a number of rural students at Nevada who wanted to go back to their own communities and practice and had an obligation. We fought very hard to assign them to that place, so they could start a long-term commitment. One would hope there would be flexibility and responsiveness to these considerations.

The most important new factor in this picture is the projected physician surplus. It has affected the American Medical Association's policies in a major way. For a long time, we thought that the market forces of supply and demand would suffice. We believed there was a true health manpower shortage and we supported the Federal legislation and policies that increased manpower. And it worked! In 1960, there were 7,000 medical students entering school. By 1985, we had more than doubled the number of entering students to 16,318. If we accept the projection of a physician surplus, perhaps we should reduce class size -- and we are considering this. However, there is a pipeline phenomenon in which people continue to pour out long after you turn off the faucet. It reminds me of when I go to the xerox machine and want 10 copies, but press 50 copies by mistake. It is very difficult to stop it. Somehow we have overshot the mark. We began to realized it by the mid-to-late 1970s. At that point, Congress appointed the GMENAC Committee to look at manpower needs. Their report in 1980 which projected a physician surplus of 140,000 by the year 2000 certainly, got everyone's attention.

It also got the AMA's attention. In 1985, the AMA expressed concern that its policies needed to be updated and created a Task Force on Manpower. That Task Force reached the following conclusions: 1) there is a surplus of physicians, regardless of specialty, in many areas of the United States; 2) there is a surplus of physicians in some specialties in most areas of the United States; 3) in most areas of the United States, there is an impending surplus of physicians in most specialties; 4) the impending surplus of physicians is likely to have a negative influence affect on cost and quality of care; 5) in the current regulatory environment, market forces cannot be relied upon by themselves to assure cost-effective medical care; and 6) the increasing supply of physicians underscores the necessity for a change in AMA policies.

Based on these conclusions, the board of trustees made the recommendation that the AMA carry out an extensive, ongoing analysis on physician manpower issues. This has already resulted in the creation of an annual report on various aspects of the manpower supply and demand problem. The Bureau has also been doing its own in-depth analysis and we end up with similar conclusions. We feel that only in this way can we monitor what is happening.

One of the pieces of this analysis has been to create several kinds of scenarios. What would be the result by the year 2000 if you were to decrease medical school classes by 100 a year? What would happen if no further foreign medical graduates were permitted to practice? There will be an annual report on manpower data that will track these scenarios.

Another recommendation of the Board of Trustees was to review physician supply and its impact on the cost and quality of care, so that educators could appropriately establish their enrollments. Fortunately, the applicant pool has been going down recently -- some 14 percent over the last five or six years. This means that one out of every 1.9 applicants is now being accepted. We need to watch this trend in terms of maintaining quality.

The AMA Council on Medical Education has been directed to monitor closely the relationship between size of enrollment and the quality of educational programs. The AMA also supports repeal of Federal regulations that were designed originally to favor and support large enrollments in schools. Very appropriately, the House of Delegates has recommended that the AMA not support cutbacks of minority and other unrepresented groups.

The AMA actively supports policies that maintain appropriate quality standards and criteria for the practice of medicine. This has come about because of recent concerns expressed in the GAO report on quality of care and the adequacy of training in foreign medical schools. The AMA also will more actively disseminate to the general public information about characteristics of medical practice and the medical community. They will coordinate efforts with state medical socieities to provide legislators and administrators with information to allow them to determine which manpower policies are best suited for their states. They will work towards a more favorable geographic distribution and make an effort to provide physicians with more extensive information on which to make location decisions.

They also will be providing medical students with information so that they can make more appropriate choices in residency training. Some specialties are obviously overrepresented and students are not necessarily selecting specialties in which they are needed. Loan indebtedness may be involved.

Medical students are coming out of school with horrendous debts. Right now, the average debt is running close to $35,000 with some 80 percent of students in debt. Despite some statements to the contrary, I can't believe that this doesn't affect their decision as to where they are going to work and how much additional training they feel they can afford. Certainly, less and less are going into private practice and more and more are joining groups and HMOs. This probably also means a decline in the number of doctors going into rural and isolated areas.

Finally, the AMA is instituting a program that will assist physicians seeking transition from full-time practice. Physicians today do not have the same career committments as their forebears. They are not as willing to practice until age 75 or 80 in the same site. They expect several career changes. I hear young physicians say, "I would like to practice until I am 50 or 55 and then do something else. Maybe I'll retire and become a rancher or something." They also are talking about shorter work hours, although there is not much evidence of this in the AMA data base as yet. They would like to work fewer nights, weekends, and hours which will surely affect productivity figures. We are also talking about different kinds of lifestyles. Finally, the increase in the number of women in medical schools and in the medical profession will certainly affect productivity as well.

In conclusion, the AMA would like to continue to be involved in the HMSA process and to participate at a local and national level. We would like to see flexible criteria that would respond to local and regional difference. Finally, even though things are moving very, very fast at the present time, and it is difficult to hit a moving target, the AMA has taken serious aim at the problem and has committed substantial resources to its solution.

MR. STAMBLER: The next person on the program is Norbert W. Budde, Ph.D., Director, Division of Survey and Data Resources of the AMA. This is very timely because there are several new AMA publications that have recently come out and because of all the discussions on data we have had here, and the difficulty of obtaining needed data, even when the sources are good. Norbert will be talking about the AMA data base and the tremendous amount of work that goes into bringing this up to date.

DR. BUDDE: Good morning. Everything seems to move faster these days. I think in medicine it is happening too. A lot is happening in medicine and with the way it is practiced and the way we think about it. The way we gather information on it and try to turn that into more information. I know we have been working with the Bureau for a long time. This goes back to the 1970s when AMA was collecting much of the data that we will talk about here today. But it was not being disseminated. We were going to all that effort, but it was not being used.

One of the things that Howard helped us to do was to convert that data into information that reached people such as you. We need your input on all three steps -- planning, executing and disseminating -- because the information that we gather has to have a purpose. That is to keep track of what is going on in medicine. You are on the front lines in one of the problem areas. By communicating that back to the Bureau and then to us, we can take the steps that you need to get the information back in a way that is useful. I would like to cover some of the history of the process, and then discuss what you would like us to do more, better or differently.

The AMA physician master file has been building since about 1970. It is not a policy driven piece but a piece that drives the policy in that the information that comes out goes into the design of the Association. What that master file attempts to answer is how many doctors there are, where they are located, when did they do any of the credentialing, and specialties both original and present. We do this not just on members but on all physicians and many DOs who are in MD residencies or others mixed in with the things we do for MDs. That is an ever increasing percentage of the younger DOs. Now obviously you do not direct data and go to the expense unless you have an explicit use. One of the things AMA uses that for is membership development. You can't recruit members unless you know who they are.

We also do a lot of survey research to help build the policies that Bud was talking about. He is one of our important customers. We have done probably 65 different surveys in the last year. They range from small to large. They are all used for a specific purpose.

The first thing we do is try to talk anyone out of doing a survey and try to find and inventory the information they need. The association also mailed some 37 million publications last year; we are the world's largest medical publisher. The data base consists of three different data bases. On one of the many student matters files we track all students when they enter medical school in the physician matters file to track them through their entire career. One we have added is the group practice file because we found that we had to track that to get the full description of what physicians are doing.

There are over 550,000 physicians in the United States. We try to track all of them, their numbers and the physician-to-population ratio. The physician master file has very clear identification of each and every physician in the United States. That is the top box. The left box is demographic information that we get from primary sources. The right-hand box also comes from primary sources, none of whom are the physician. The center box really comes from the doctors. But a key to this whole data base is that we do not rely on secondary information. Everything comes from the agency that confers. I tried to figure out a way several years ago to collect all these activities that we do. I firmly believe that identification of information needs is the key to the whole operation. You have to identify up front what you need it for before you get started.

Of course, the point was to use the information. I am interested in learning how you can use the information and what your needs are. The way we work on the need is in all our surveys -- we find out what people are interested in and what they ask us. Then we try to find ways to forecast. We also do telephone interviewing. We are expanding this area because we cannot get the number of returns through the mail when collecting information.

We are currently involved in 3/4 million dollar project on young physicians. Susan O. Whitmore is managing the redesign of our master file. We had a very interesting piece of legislation passed last fall called the Health Care Quality Improvement Act of 1986 that is intended to find out which physicians have disciplinary problems and make sure that they cannot move to another state and practice again. We currently track all state licensing boards disciplinary actions. Secretary Bowen noted in a presentation, "When a hospital takes discipline we are planning to add this to the master file. We make that available to the hospital when the physician applies." This includes malpractice settlements, judgments and awards.

One of our surveys is to validate information. This marvelous machine costs about $10 million a year to operate. It starts with the medical student, goes on through their residency and credentialing periods. Then the practicing physican becomes the source. These are very quickly a litany of the primary sources from which we get data on all physicians, members and nonmembers. The medical schools provide matriculation information each year. There is a change of status report. Whenever a physician does anything out of the ordinary in terms of moving through their program we receive that information from the school and adjust the file accordingly. In due time, virtually all of them graduate. That information is provided by the medical school, verified by the primary source. We also start collecting information from the students by a postal mailing to find out where they live. We found most mail going to the medical school goes into the college mail room and into the trash can. We would rather direct it to where they live so we can communicate with them. The residents provide additional information such as residency location, where they plan to practice, etc. That is a very dynamic period. We take that mailing result and combine it with the national residence matching program, which assigns 80 percent of the new students to a residency program. That information is combined, put onto precoded forms and sent out to the 4,800 different accredited residency programs. It reaches closer to 6,000 different hospitals.

The information received from this survey is recoded, and verified once they have arrived at the program they intended to attend. If they complete the program successfully, that is entered. This stage is where we get information on foreign medical students. We get their certification and their foreign credentials and add that to the master file. We receive approximately 80,000 questionnaires. The licensing information comes from the boards and you work with the boards frequently. They provide licensure information and revocation. The specialty boards provide certification information. The national boards of medical examiners give us the national board results. Five Surgeon General's report on government service, including the National Health Service Corps and others, provide primary cross-referencing information.

Then finally, after all those primary sources are exhausted, we start to collect information from physicians on their professional activity. Each year we do approximately 300,000 to 400,000 forms. We collect the hours worked, by activity, location, group and hospital.

Group practices have grown up very rapidly. Last year 140,000 physicians have been identified as working at least some hours with a group practice. Each month we get the disciplinary actions from the Federation of State Medical Boards, which verifies whether or not any disciplinary actions came through the state that we did not get directly. We have an alert letter that goes to any state where a physician is licensed. When Oklahoma revokes a license or disciplines a physician, a letter goes to all the states a physician is licensed in telling them to contact Oklahoma on what actually happened as it may affect their decision. We have no disciplinary role. We just make sure the information moves around. There are 2,100 different institutional data providers. And that does not count the residency, which would include another several thousand. This is the physician's professional activity census. It is very detailed.

Then there is the group practice census. These data bases come together and we can now link the doctor with this group practice and vice versa. You see the different sets of information they have. Doctors move a lot. Now 200,000 of them move each year but that is how many moves we record. Mr. Peterson was telling me about a doctor that has a mobile office. He operates it in one town in the morning and another in the afternoon. We get many of these address changes from specialty societies, licensing boards and secondary sources such as hospitals and the doctors themselves. We also do a slip service to make sure we do not miss any deceased physicians, although many of them write us. We like to make an assumption but we would probably be wrong. We do two million changes a year to that file of 550,000 physicians. Even with all this, you and I know it is not totally accurate. Two million changes a year makes it very close, but not perfect.

We have also created a physician movement report that helps us to keep up with physicians and sends this information with these changes and disciplinary action to different state and county societies that are interested in keeping track of physicians. We also do custom data requests. If you need something specifically, we would urge you to talk with Howard and Dick's staff. Make your needs known so they can be coordinated. If you need it, chances are so does someone else. Last year we did 250,000 physician profiles for hospitals. We make sure the list is not abused.

The credentials reviewed for the Federal government alone were 120,000. We did it for the armed services, the VA, Public Health Service, the Education Commission on Foreign Medical Graduates, the FBI and the Postal Service, licensing boards and so on. We help these agencies and they in turn help us. We need the information they can provide. After going through all the data, we come out with a useful data base.

We have just handed out a packet of information. Included in this packet is a state summary of data on physicians as a handy cross-reference of different states, and other reference material. We will try to make the publications available to you at cost.

Thank you very much.

MR. STAMBLER: We are all interested in cost issues and the problems of cost containment. We have always been happy to work with the AMA. We often have supported AMA activities. By virtue of support we often get a free copy of documents, but in addition to that we purchase copies, using government purchase orders for additional copies because these things are so valuable to so many people for so many different purposes. Obviously, we cannot expect any association to give things away for free. Even in the government it becomes impossible to give things away, although the government provides resources for many of these things.

Our last speaker on the program is a very important person in the health manpower data arena. He is responsible for all the data that the American Dental Association collects, publishes and analyzes. Kent Nash is the Director of the American Dental Association Bureau of Behavioral and Social Research and one of the long-time friends and supporters in the arena of data.

DR. NASH: This is my first introduction to this arena. I did not realize there was still a frontier in the HPOLs and MPOLs. The best thing for me to do is follow up with what Norbert has presented as there is much overlap.

One of the major things that Norbert has to deal with is that there are considerably more physicians, and the issues and sources of information on physicians has grown dramatically. The number of dentists now is estimated in the neighborhood of 165,000, with 140,000 professionally active.

I would like to review the sources of our information and how they might be made available to you and our overall data collection agenda. Then I would like to give you some things to think about in terms of the planning function that you have.

The association's center of activities is a membership records system. We essentially work off the membership records system. Membership records are obtained and used as our source of information about dentists and the practice of dentistry around the country. We want an information system that lists all living dentists in the country, member or non-member.

We want this information for recruitment and that forms the basic pieces of information that you will find in almost any kind of membership records system. Attached to that we have additional pieces of information to take us into various uses of that record information. Dental school and graduation information we get directly from the school. Specialty programs and specialty designation data come from those programs if we know the year of graduation. We get information on their private practice location, type and retirement year. Primary or secondary options in dentistry are obtained through a survey of all the dentists in the country.

To form our manpower analysis and estimates of the number and supply of dentists in the country we use their geographic location; what they are doing; what they are doing on a primary basis versus secondary. That can be examined in terms of age, experience, distribution. It serves as our basic set of information.

We collect the name, address and location and private practice location. Through zip codes we can hook into other sources of data. We can subdivide our information by county and zip code area.

We get a number of requests either from states or people such as you or schools, etc, to generate information on a county basis. Through this mechanism and the zip code we can then prepare any kind of a request for information that combines this with either census or area resource information on a county-by-county basis. We have standardized that so that every single county immediately has information available. It seems that most of the requests vary, so our requests are tailored.

That information also serves us in a second way and probably the most important way. Our information is dated and we can track the changes over a period of time. We use this tracking to examine other questions about practice of dentistry, recent graduates, whatever. This takes us into our sample surveys. Most of those characteristics we include on that record since they are put on the record for every dentist in the country. Then it makes our assembly, when we wish to examine an issue, much more efficient. For instance, there is much concern right now in doing a sample survey of women dentists. The fact that we have gender on the master file means that we can go in and take a sample of any particular entry to look at the results. We have some of the surveys then that are generated from the records that we put together. We can take a sample of private practitioners which forms our basis for a survey of dental practice, a survey the association has conducted since the early 1950s.

Much of the economic information, hours, visit, staff size, composition, types of staff, fees, expenses, income, is a fairly comprehensive survey done annually basis. We have conducted fee surveys on a periodic basis. This survey of recent dental school graduates is an update done one year after graduates have begun to locate.

Our surveys are completed on a periodic basis annually. The membership records, maintained, updated, cleaned, and new dentist records, are part of our system. The other information we attach to that, such as primary options, secondary options, whether or not they are in private practice. That is done on basically a three-year cycle. In between, we do projections, forecasts, etc.

This is a quick overview on our source of information that can be generated on a national basis, regional basis, state, local and county basis. All this information can be pulled out in that way.

There have been many questions thrown to us recently about what is now the manpower problem. Are these data of such a nature that we should continue its collection? Should we change and modify, increase, decrease, what have you, because there are those who feel that manpower in dentistry now is quite different than a few years ago.

The industry is having a business problem. There was a reflection into the practice of dentistry that came from the early 1970s and the funding of dental school activity that took place. There were a number of things in the 1970s that put pressure on the practice of dentistry around the country.

You hear a lot of screaming from practitioners having a business problem. They cannot keep their appointment books filled, because there are too many dentists. What they are reflecting tracks along with the terms of their average income. In the mid 1970s the wage-price freeze was imposed in 1972 to 1974; the dentists took a pretty good dip in that red line. The red line is their average income after you have adjusted for inflation and cost of living. They came out of the dip from the mid 1970s on up through 1982, the average income was declining. For a period there it declined at a fairly good clip. When you start to put things together there were some real pressures on the practice of dentistry around this time. Part of that came from the rapid growth in the number of dentists that we witnessed during the latter part of the 1970s. Falling income and relative price of dental care began to fall. All these things are usually the little signals that economists look for if industries or groups are having economic problems. Some of those things were showing up in dentistry together with some decline in market share. The number of patients they treat on an average per year was falling on a per dentist basis. If you recall there were many things in the latter part of the 1970s putting people under pressure. The latter part of the 1970s saw some of the highest rates of inflation combined with high interest rates.

During these periods of time, people were trying to keep intact the income and the earnings they have. The pressure on the practitioners was in an economic sense. But since 1984, the red line has started to turn up a bit. In 1982, the average stabilized. The past two years have seen a growth in the average income, which has gone beyond the inflation line. The average visit in the last few years has begun to grow again. Relative prices have stabilized, and have increased. The picture in the last few years has been good. I project for the next few years that dentistry will continue to see an upswing.

The manpower in the last few years has decreased considerably. Several years ago most of the articles written were from the point of view of the practitioners. We are very concerned about the practice of dentistry. It has been two years in the ADA House of Delegates that manpower was not even mentioned. Virtually nothing has been raised in the House of Delegates as far as any semblance of a manpower problem from their perspective. In my opinion the manpower problem hasn't gone away. The pendulum has swung. It is now in the hands of the dental education sector.

Much of Bud's talk with respect to the medical side of things is similar to the dental. Applicant pools have virtually gone away. I am looking at average growth in dentist income and the average growth in the number of applicants to dental school. Since the mid 1970s the drop off in applicants has been overwhelming. It has dropped off by more than 50 percent. The same pressures on dental school have been experienced in our medical schools. When that applicant pool drops off, that indicates the demand for your services has dropped off. People are not demanding dentistry services as often, so the question comes to the dental schools exactly the same as to the medical schools. You need the best students to be physicians and dentists. Dental schools are competing with engineering programs and computer science programs for the best students. It is putting pressure on the schools and medical schools as well. This is where the manpower problem really exists. Dental schools are closing. There is potential for serious regional and state dislocation if some of those things take place.

While we are doing some manpower projections, and I think these are somewhat similar to what you are seeing, we are projecting generally an increase throughout the rest of the century. We are projecting increases to the end of the century with the ability to make quick adjustments. It is fairly sensitive to what happens in the dental school arena. Information we are getting from the American Association of Dental Schools is pretty pessimistic. They are projecting first-year enrollments to be quite low all the way to 1995. Three thousand graduates on an average from the late 1990s onto the year 2000 does not seem to be out of the question. In fact, it would mean the kind of slowing down to the level of the 1950s.

We have gone through a fairly sizable increase in the number of dentists. It has affected the age of doctors. We have many dentists now under the age of 40. The bulge in doctors at this time will move across the age distribution over time. In a few years you will have dentists who are somewhat inexperienced, gaining experience and becoming more efficient. In about 15 years, you have the bulge in the 45 to 55 year-old group. That is generally the period of time that we see dentists being the most productive. That is the height of efficiency. Around the year 2000, the competition will be much greater. The productivity will be much greater and the demands for new dentists will probably last on out until that time. If you go on another 15 years, to 2020, then the bulge now under 40 is beginning to go into a retirement period or a semi-retirement period. There will be a tapering off period of productivity.

What kind of trail over that 30-year period have we left back at the other end? The projection of the American Association of Dental Schools and the ADA is that there will be a moving but not replacing surge. By 2020, when the current bulge of dentists are in retirement or semiretirement, there will be a dearth of dentists practicing. The potential for care will begin to decine somewhat.

On the supply side, the forecast or analysis there is more stability on the other side of the question where dentistry is concerned right now. In fact, if you could talk about a supply side, probably the most unknown of all is what is happening on the buying side by the public.

There was an article that I just happened to see in USA Today, by Dr. Lowe of the National Institute for Dental Research, who made a presentation on a very large comprehensive oral health examination study of the working public. He presented the results of that at the ADR meeting in Chicago. Thirty-seven precent of children below the age of 17 never had a cavity. Dr. Lowe attributes the success among younger and middle age people to decay fighting flouride in the water and toothpaste plus better hygiene. More middle age people are keeping all their teeth. Four percent of those under 65 are toothless versus ten percent in 1960. Cavities and gum disease remain a problem for many adults but they moved to a different location. Among those under age 65, 20 percent have one or more cavities on the root of their teeth, 60 percent of those for age 65 and over. Of course those age 65 and over brings in the question of much interest, particularly with the projections on the growth in the elderly population.

I think that sums up where the ADA and the profession are really beginning to ask more questions, the disease patterns, the changes in the occurance of carriers and other oral disease, how that is going to continue over the future. The decline in cavities is going to be affected on the one hand and on the other hand people keep their teeth longer and are subject to risk longer. So the change inference and patterns in diseases are of continuing interest.

Second, how are those changes being converted into service. We know that many individuals who have oral diseases do not go to dentists. With these changes, how will that affect going to the dentist?

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The continuation of growth in dental insurance, 50 percent of the population has dental insurance, grew rapidly over a short period of time. Will that continue? Will the number of people with coverage continue to grow? What will happen to the benefits? Are they going to change? Overall economic stability is the best thing for the dental industry, having the growth continue. Will it? Of particular interest at this time is the growth in the number of elderly; the excess issue, particularly how it affects the elderly. Are the elderly similar today as to what they were in the past 15 years? The elderly represent 13 to 14 percent of the population. These are the same elderly we have seen before in terms of health habits, in terms of medical and dental health. All I can assure you is that probably the paramount thing that affects the association at this time is how it applies to the manpower problem on the demand side of the issue. The buying habits and patterns and how they will change over time. Once we know something about that, we can begin to be able to project what manpower problems will be on the supply side and how they might be directed on the state, county and city basis.

Thank you.

MR. STAMBLER: It is important to recognize that although most of us are here because of concerns with National Health Service Corps placement, the issue of dental manpower has been ignored because the Corps has very few dentists to be placed. Primary care is not the only important issue. While it may be of primary importance now, access to dental care over the years is something we should keep on top of.

We have time for some questions to any of the three presenters.

MR. MCGINNIS: Dr. Baldwin, you stated that an excess number of physicians would have a negative affect on quality. I realize that the decreasing number of applicants may indicate that quality could go down, although we have to assume that when they finish school they are trained physicians. But, how does that excess number affect the quality and care negatively, when it would seem that more physicians could spend more time working with each individual and make better decisions.

DR. BALDWIN: It seems paradoxical that it would go the other way, doesn't it? Those few studies we have done indicate that the less often you do a procedure, the less well you do it. Hospital surgical data show that those physicians who do fewer procedures have poorer results.

Second, specialists charge more than generalists. So, as they begin to respond to the public's need for primary care, they will probably charge more for it. Third, they generally order more costly procedures. Costs will rise if more doctors do more procedures in an effort to maintain income and competitiveness. It may have a negative affect by driving up costs.

Finally, the number of foreign medical graduates has been rising very fast over the last 15 to 20 years and there have been some real questions about the quality of their training and care. During shortage times, this did not attract a lot of attention. Unfortunately, there are a sizeable number of physicians -- probably several hundred -- currently practicing in the United States whose medical school records are missing or non-traceable. These are chiefly graduates of foreign or offshore medical schools.

MS. SIRMANS: Dr. Baldwin, with the changes you talked about in terms of where physicians are practicing, such as the HPOLs, what changes have occurred in the education programs to acquaint them with some of the differences in the practice?

DR. BALDWIN: As the practice of medicine changes, I think we will have to change the way we educate students. So far, over 95 percent of the clinical training in most medical schools takes place in highly specialized, tertiary care hospitals. More recently, partly for financial reasons, some of the newer schools have been using community hospitals for training their students. This will provide the students with a more well rounded picture of community medical practice. I think educators are also accepting the fact that some of the emerging clinical sites, such as rural satellite clinics, ambulatory surgery centers, primary care health centers and HMOs have much to offer.

MR. ELISON: I have a question for Dr. Baldwin and Norbert Budde.

It would appear that the recent graduates are afraid of solo practice. That is part of the problem of recruiting physicians to shortage areas. How can we help them realize that it is possible to deliver quality care as a sole practitioner?

DR. BALDWIN: A well-trained young physician is very unlikely to go into practice in a community where there is no hospital. This is a "catch-22" for rural communities because rural hospitals are feeling the financial squeeze and some are being phased out. Many people would like to centralize health care in larger cities. I think this would be a disaster for people in isolated rural areas. You have to keep that hospital going if you hope to get someone to come there. Also, few physicians want to practice solo, ambulatory care, because they do expose themselves to all kinds of problems -- lack of support, greater liablity and less renumeration. Rural practitioners don't receive the same level of reimbursement as urban physicians. It's a pity, because a one percent decline in the reimbursement patterns to urban physicians could actually result in a six percent increase for rural physicians.

MR. ELISON: You referred in order to get data we go through the state medical societies. That was an incorrect assumption on my part. We have a state Department of Health that will deal directly with you.

DR. BUDDE: I would not guarantee what I said, but I mean to say we are perfectly happy to work with you. The reference I made was to Howard and Dick. You talk to them about your needs and they work with us to provide that across state borders. Before we were doing a la carte work that was expensive for us. But sure, give us a call, although it helps if you work through Howard.

MS. PHILLIPS: Since internists represent such a wide variety of specialties, it would be helpful to those using your data if you would organize it so that general internists would be separate from the specialties aggregate?

DR. BUDDE: That is a very good comment. The way we do it is we have some 83 or 84 different specialties we record that are self-designated specialties. There are a dozen in internal medicine. When we do the 82 break-out as we call it, they are all there. Then we collapse it to 36 for some publications. You can get those broken out however they are needed.

MR. STAMBLER: Any other questions?

MS. SIRMANS: Dr. Nash, you discussed the supply of dentists. What about the distribution? In New York State, we still have to work to get dentists in some of the inner city areas and some of the remote areas. Is there anything you can comment on about that?

DR. NASH: It is a question where there are two schools of thought, the supply and the distribution. We have done some movement, relocation, and migration studies that conform to some of these things that have been done in medicine. There are certain things that will attract and others that do not. The things that seem to explain why poeple move in certain areas tend to be more related to economic conditions. All of you have spoken to that in terms of what you have discussed here. Why would a physician go to shortage areas? Some of it is geographical, social, but most of it is economic conditions. Either the economic situation is not favorable or something. I do not think there is any question about it.

One theory is that when you have the supply, it is like pouring sugar on a coffee table. When you drop it some eventually will get clear out here in the remote areas after you pour a lot on the coffee table.

That is a very expensive way to try to get people to a remote area. To some extent that is what has happened. It has gotten people out in some of the places. But there are always areas way out there that are just never going to be touched. Part of it is economics. What I did not realize when you are making some of the decisions is that you are assisting the private enterprise system. Where most health care, at least dental, is delivered through that kind of process, it can only go so far. What you are doing is extending that because it won't happen on its own. The other part of the supply issue beyond dumping a lot is to do exactly what you are doing. Let the basic supply adjust to the conditions. But then there are other places where other kinds of decisions need to be made and other mechanisms need to be put into place to fill up some of these other places.

MR. STAMBLER: Well, it is after 12:00 now. I would like to extend my sincere thanks to Kent Nash, Norbert Budde and DeWitt Baldwin for being here and for engendering a fascinating discussion. Thank you for your excellent presentations.

(The noon recess is taken.)

STATE AGENCY EXPERIENCE/METHODS EMPLOYED IN POPULATION GROUP HMSA DESIGNATION

Paul LaBrec, Arizona
Paul McGinnis, Oregon

MR. LEE: Good afternoon. We are going to have panel discussion on population group designations, migrant designations, etc., and then split into small groups. The first group will deal with frontier and other rural health care problems. The other group will discuss urban health care problems. After that we will have one group dealing with migrant and Spanish-speaking and other similar population groups running parallel with first a rural and then a migrant and Spanish. We would like some recommendations to be presented to the assembled multitude tomorrow morning. The migrant and Spanish group will be chaired by Phil and Dave. You can choose whichever appeals to you at each of those times.

MR. SALLADAY: Good afternoon. We have two state panelists who will be discussing population group HMSA issues.

Our first speaker is Paul LaBrec from the Arizona Office of Rural Health.

MR. LABREC: My presentation is on population HMSAs. I would like to cover four points: the Federal regulations for designation of population HMSAs and how they differ from geographic HMSAs; the population HMSA situation in Arizona; comments about a new type of population designation for the HMSAs on which some of you may be working; and some ideas for preparing population HMSAs.

First, how Arizona differs from other areas of the country. For a rational area for a population HMSA, you are looking at not a geographic boundary but a standard neighborhood. A standard neighborhood is a neighborhood with a strong self-identity, homogeneous economic structure, limited interaction with contiguous area, and a minimum population of 20,000. There should be identifiable access barriers to medical services for the population under consideration. These barriers may be cultural, economic or linguistic. For example, in Arizona we have HMSAs in which the population is predominantly Spanish-speaking. Also there are HMSAs in which providers in the area do not participate in the Medicaid (AHCCS in Arizona) or Medicare programs. The final criterion is a population/physician ratio of greater than 3,000 to 1, which is self-explanatory.

In Arizona, we have currently nine population HMSAs. There are, first, Indian poulations including the Navajo Reservation (the largest in the country), the Gila River, Hopi and White Mountain Reservations in the central and northern sections of the state. There are four population HMSAs for the medically indigent. There are two poverty or migrant population HMSAs. I will describe some of the medically indigent and poverty HMSAs to give you an idea what kinds of population we are talking bout. Central/West Pinal County lies outside the city of Phoenix, a city of roughly one million persons. The area is rural agricultural land. There are three sites that serve primary care service to this population. There is a large "notch group" population in this area. I do not know how many are familiar with the term "notch group." The term refers to those who fall in between being covered by Medicaid or other state Medicaid-type programs and the ability to pay for health services or afford insurance.

In this HMSA the medically indigent population numbers around 9,000, of whom 21 percent fall below the Federal poverty level. We also have a migrant HMSA. Guadalupe, outside of Phoenix has a large number of migrant farm workers who come into the area as well as a population of Yaqui Indians. South Phoenix and South Tucson both have a large medically-indigent population. There is a large percentage of Hispanics in both of these neighborhoods who experience cultural and linguistic barriers to services. There are three primary care sites in both of those areas. We have been fairly successful in recruiting bilingual NHSC health care providers for those areas (an important consideration). Not only is it important to be able to speak Spanish in these areas but you should have a background in the medical beliefs of Mexican-Americans. Many people, particularly if they are recent immigrants from Mexico, are accustomed to a different health system. It is advantageous for the provider to know this.

The indigent population of South Phoenix has a greater percentage of blacks than in other parts of the state; and a large number of Hispanics. Blacks and Hispanics comprise 20 percent of the population there. Economic and cultural barriers, as well as transportation barriers, exist. There is a very low mean income and poor transportation services. In that particular HMSA, 14 percent of the population speaks little or no English. There is also a large "notch group." In addition, there is only one physician who uses a sliding fee scale in that area.

We have other poverty populations in Somerton (in Yuma County) in the southwest corner of the state. Yuma county is a large agricultural area with a large number of migrant farm workers. There is a Migrant Health Center there. Some have had problems in service delivery to that population which I will talk about in a minute. Now, this was a summary of the population HMSAs in Arizona.

The future plans for the state include an increase in OB/GYN designations, because we are experiencing -- as are other states -- an increase in the dropout rate of rural OBs due to the recent increase in malpractice insurance. We have, also, had requests for OB/GYN HMSAs from various parts of the state. There are both geographic and population designations that wish to obtain OB/GYNs.

We have a large homeless population in Phoenix. We are trying to work on a designation for that population, which I think would be a first. Has there yet been a homeless designation? Is anyone working on one in their state?

MR. SALLADAY: There is one designation in Oregon that includes an adjustment for homeless population. Paul McGinnis will touch on that in his presentation.

MR. LABREC: In Phoenix there exists, through a grant from a small foundation, a shelter for the homeless that provides meals and shelter and has part-time clinic hours, currently run by a volunteer. There is a total of .8 FTE between three physicians. Part of the grant money pays for supplies for that clinic. Since there is a structure that exists for delivery of care we are trying to get a HMSA for that area, if we can possibly arrange it.

There are three main sources of the homeless population. The largest is the economic factor. People come into the Sun Belt looking for jobs, moving out of the extreme north and so forth. When people get there they discover that there are jobs, but most of the jobs are in the high tech service area which definitely require skilled labor. Many people are not able to obtain these jobs. They are left with not enough resources to return home so they become part of the homeless population of the city. Families and children comprise increasingly larger portions of the homeless population. The second reason is the massive deinstitutionalization of the mentally ill, which occured in the mid and late 1970s, putting many CMI persons in the street.

Lastly, in the 1980s, many Sun Belt and other cities experienced urban renewal. Parts of Phoenix have put people out of low cost housing into the streets. Current estimates for homeless in Phoenix are about 4,800. We are talking about a sizable population, easily meeting the 3,000 to 1 criteria for HMSA. While the poverty level in the county as a whole is about 10.5 percent, it is virtually 100 percent among the homeless.

There have also been estimates, in a study that was done in connection with this grant, that roughly 60 percent of the homeless are unemployable, of whom 20 percent are CMI, 20 percent chronic alcoholics, 10 percent are physically disabled, 5 percent socially maladjusted and another 5 percent are what they call worn-out workers. There are many health problems associated with this population that are exacerbated by their living conditions. There are many problems caused by sleeping out of doors and from stress. You see a lot more colds as well. There is a higher risk of skin disease among this population. This survey also indicated about 28 percent of the homeless in Phoenix were receiving benefits from various entitlement programs. We thought it would be higher. Twenty-eight percent receive food stamps. About 39 percent do have some form of employment, though it is often irregular and seasonal. Eleven percent have identified themselves as self-sufficient. What that means is they are regularly selling plasma for $20 a week or collecting aluminum cans. Nine percent said they combine the various strategies. It is planned to set up the existing center as an outpatient clinic for an NHSC physician. We are trying to use this as an intake point at which to let the homeless know about the assistance programs, see who qualifies for what assistance programs, and possibly point people towards various educational training programs for employment and so forth.

Some of the major problems that we have encountered in developing the various HMSAs in the state are: first, counting persons, which is most difficult for migrant designations where you are dealing with a large, sometimes undocumented population. We have tried to work with various labor bureaus and people who are trying to keep reliable estimates.

In conjunction with another project in my office we have a grant to develop an intake form for health providers, which we are piloting in Yuma County, where the largest percentage of migrant farm workers enter the state. When the migrants come into the clinics in the area, we will try to get medical histories and backgrounds, and try to document numbers and health histories. Most of the information you find on the health of migrants is anecdotal. Very little hard data are available to use to design programs. This data base is very much needed. We want to document the population and know the needs of the population.

In developing a migrant HMSA, you need to know where migrants go for health care. For example, in Arizona, about six of the major growers in the Yuma County area have contracted through an insurance company to one major provider on the Mexican side of the border. That provider has seen most of the farm worker cases that are not covered under workmen's compensation. Since this is the case obviously there is a large incentive for people to go outside Arizona for health care. Thus setting up a clinic on the Arizona southern border may not be effective.

How do you come up with the correct FTE count for providers serving migrants? First you try to find the providers. How can you document what percentage of their portion is spent serving the migrant population? Asking about sliding fee scales and also Spanish language provisions would apply in this case.

MR. SALLADAY: If there is a question or two on Paul's presentation, we could take them now.

You mentioned 4,800 as the number of homeless in Phoenix. Can you identify the source for that count?

MR. LABREC: The figure comes from the Arizona Coalition for the Homeless. There was a study out of which came the numbers for this intake center.

MR. STAMBLER: Was this a group that was pushing for homeless assistance and/or do you have something in Arizona as in Washington, D.C., with two groups fighting each other, i.e., the government versus the activists? Do you have that same problem in terms of a disagreement on even the magnitude of the number of homeless or is it more or less agreed that there is a certain number?

MR. LABREC: We have conflicts. Part of the problem in documenting the numbers is that some people might try to push large numbers under a rug. Some contend that there really are not that many homeless, so it is not a great problem and does not deserve attention. The problem is what to do about it. It is agreed by many that this is a big problem in the southwest. There have been demonstrations by homeless on the mayor's doorstep in Tucson. We have had a lot of problems in the organization of services, especially soup kitchens. There is the Primavera Foundation and others trying to set up limited shelters and feeding areas and they are constantly coming into conflicts with neighborhood associations.

MR. BRAND: What is the best source of data you have and how good is it for counting migrants?

MR. LABREC: Robert Trotter, an anthropologist at Northern Arizona University, has come up with a figure of roughly 22,000 farm workers in Arizona. This is a conservative estimate. He arrived at this number by counting the total acreage for each crop that needs farm worker labor (using the aid of agricultural extension grants) and then figuring the total number of people required to work this acreage. Finally, he added a small factor for dependents of farm workers.

MR. SALLADAY: Thank you, Paul, for your presentation. I would now like to introduce our next speaker, Paul McGinnis from the state of Oregon.

MR. MCGINNIS: I will focus primarily on two health manpower shortage areas in Oregon, one designation that worked and one that did not. First, I want to share a couple of my general thoughts about HMSAs.

The longer your designation request is in length, the less reliable it will be. If you are going to write them, make it brief. I think the reviewers would agree when they see one that is thick they know that something is filling it up.

The other thing is that I have noticed in the time I have done reviews that the longer the Bureau holds the designation request, the less understandable the response will be. Through the years, some beautiful letters have gone out under Howard's signature that are quite fun to read.

My first health manpower shortage area was a migrant and seasonal farm worker request for Jackson and Josephine Counties in the southwestern portion of our state. The primary crops in the area are pears, apples, peaches, strawberries, onions and hops.

The area has one major city, Medford, which is in Jackson County. Below is Ashland, famous for Shakespearean theatre. If you ever have an opportunity to get to Oregon, please come visit. There are a substantial number of migrant and seasonal farm workers in the area. The obvious barriers to care are economics, language, cultural differences, transportation, environment and working hours. A lack of continuity of care due to the mobility of the population combined with provider insensitivity about their needs and a lack of knowledge of available services create additional barriers.

If you are moving as much as migrants do, it is difficult to determine where to get care, i.e, if you get sick here in San Diego, where would you go? It is the same for them with the barrier of language added on.

Essentially in your HMSA request you need to make a population count for a fact there are no sources of complete and accurate year-round data on migrant seasonal farmworkers. The information is difficult to retrieve from growers and the migrant population themselves. In Oregon, we have some county-level data and a methodology for estimating the population of migrant and seasonal farm workers in each county. The Migrant Health Task Force meets bi-monthly. It deals specifically with migrant health issues and endorses the estimates. There are at times differences of opinions from local people in numbers we get in our estimations. We come to an agreement on that when we provide information to the Feds. That is our source of information for MSFW population counts. The program to estimate is called the Methodological Design to Estimate Target Population. The 1983 final report is available from the Office of Migrant Workers Safety. The information in that methodology design can be duplicated in each state because the information collected is from forms that are common. Two sources of information that make up this estimate, after you work the statistical magic, are Employment Division ETA Form 223 and census of agricultural material. Then you massage those numbers and get an estimate for the county. The ETA form is registered by the U.S. Department of Labor. It should be collected at your state level. When you do that methodology design, you essentially get a high and a low for the time of year that people are available.

To establish a midpoint, just add the numbers and divide by two. Take that number for the migrant and seasonal farm worker population and add. Migrant and seasonal farm workers work in the packing industry. Through talking with growers, you can make an estimate. In this case, the packers were an addition of a thousand people for that service area. Determining your percentage of migrants is real easy on Form 223. They have what they call intra- and interstate populations for these folks who are workers. Intrastate workers are your seasonal farm workers. Interstate are the migrant population. After you have those figures, you need to annualize that number to reduce it down. If they are present in the area eight months you would multiply that number by a factor of .83 or whatever the percentage of time of year spent. Your designation occurs over a time period of a year. Not just for when they are present.

Physician count is essentially the same in each one of the designations. It has been hit upon throughout the conference. Get the licensed physician, do your FTE counts and counts for subsidizing. The people who did the designation request in Jackson and Josephine Counties had some other information. This is where they blew their designation and why they do not have one. In Oregon, we have six whole county migrant and seasonal farm worker designations. Essentially, after they arrived at a discounted FTE from 138 down to 97 or 83 providers, they looked at the percentage of physicians in other counties serving migrant and seasonal farm workers. They made an average on the right as 2.7 percent of physicians in those areas available that when you apply to the 93.07 full-time equivalency in the area, you arrive at 2.51 FTE available to serve the migrant and seasonal farm worker. The population totaled near 10,000 or so. You can't do that. What you need to do is to go back to these people and resurvey the population. Looking at the various factors that would imply that a physician is accessible to that population. Are they Spanish-speaking? Do they employ a sliding fee? Do they provide any free care? Are they accepting new patients? Do they accept Medicaid? What percentage of your practice is devoted to the migrant and seasonal farm worker population?

Although I have never seen it actually used in the determination of whether or not a HMSA should be there, evening hours should be mentioned in your designation request. Remember to only include what is going to help your case in an application. That one actually did not work but essentially the methods for counting the migrant and seasonal farm workers population are similar in all areas in Oregon.

The second designation is one that is near and dear to the folks in Rockville. They face a special population for the poverty and homeless of Multnomah County, which covers Portland. Portland happens to be one of the most saturated markets for physician health care in the entire country. I think the population-to-physician ratio is below 650 to 1.

Essentially, there is a homeless population and poverty population that was proposed through group designation. This took two and a half years to get designated through differences in what we were estimating as counts and the availability of providers. Be prepared for damn good hard questions that are raised on the homeless counts and accessibility for the FTEs in the area when you are in a community with as many physicians as in Portland, Oregon.

Howard mentioned something I would like to mention briefly. A bill was passed through the House to make homeless a special population group for health manpower shortage areas in an area. That is very helpful for us. There are some things you will need to consider when you are doing a homeless designation. The poverty data were collected for the Census in April 1979. Things were not too bad in Oregon in 1979. They have gotten progressively worse. The information there is difficult to deal with and to get.

Phil mentioned food stamp counting and so forth. The food stamp eligible needs to mirror the poverty guidelines and also the state's commitment to that program, which Oregon has a very poor commitment. Poor people are eligible for that in Oregon and if anyone has ways of updating poverty except for trying to extrapolate on employment figures, I would appreciate the citation on where I can get it.

When you are looking at that general population you also need to include HMOP population and physician from your FTE counts as well as those people who you may consider homeless. Medicaid recipients in the area, you have to exclude because they have access in Oregon. Not from all the states but Oregon was able to get a waiver from BHCDA to essentially start Medicaid PPOs. Physicians formed programs and organizations to force Medicaid clients into choosing among groups in place. It is all prepaid. The providers are making a healthy piece of change. The state is saving money too. You have to eliminate those and watch for whether or not your Medicaid program does anything of that nature.

You need to document those barriers for your homeless population in specifics. Trying to get across rivers and so forth. Other designated groups in your urban areas are already counted even if they are homeless. You need to back those out too. You have to look at other designated groups. Migrant and seasonal farm workers who happen to work in the fringes of a county. That may be quite large in the West. You also have to look at the private practice physician who is available to go through the estimate of whom is available to serve the low income homeless population through survey method.

Take a look at any medical school training program. They cannot turn anyone away. Those are FTE counts you have to apply to the homeless population. Hospital outpatient services are used. Even if you walk through the emergency room door, the social directors of the hospitals can refer you to the appropriate slot, which may be their outpatient department. You could not count it as an emergency room visit, but instead an outpatient participant in the hospital. People are accessing care that way. You must make an estimate of FTE availability through an evaluation of that. The area that was proposed was the entire Multnomah County. What actually got designated were census tracts underneath the Burnside Bridge near a place called Baloney Joe's.

MR. SALLADAY: I think we should note the original request was for all the underserved populations in Multnomah County, not just the homeless population. We asked for more information, which included some of the sources of care Paul just mentioned. It was more than just the homeless that was requested.

MR. MCGINNIS: True. I did not mean to mislead anyone. But two census tracts were designated and they continue to have the status that comes in being a health manpower shortage area.

That was all the information that I had planned to share with you. If you have any questions or want to see how we do these, I have cards with the original file in my room.

MR. STAMBLER: I do not plan to be defensive. This was really one of the better presentations of HMSA issues and problems that I had seen. The fact that it did not get designated the way you wanted shows very clearly some things that are difficult to show and prove. This is an important part of what I think we all need to know.

You did mention something about one study, the migrant study. You also mentioned ETA. I would appreciate getting some of that. It may be of use to people who do not know how to follow through on HMSA requests.

There is one other thing I wanted to mention. The Census Bureau just released a major report on Federal and state benefits to people in poverty. They studied people living in poverty, determined what kinds of benefits were accruing to them, e.g., stamps, health care, etc., and where they went. There were quite a few over the poverty level who also receive these. And, there were many below the poverty level who did not. I do not know if it is a regional study or a state study. This is something that should be followed up on and made available to everyone. You may find it more quickly in your own area than we would. It takes very good source of information to determine what kinds of benefits go to what people.

MR. MCGINNIS: I did want to make a point which I forgot to make. It helps make Salladay's assignments easy, that is if you think something sounds screwy, it probably is. Give these guys a call and run it by them before you waste the effort of doing it. They might not give the answer to you in writing but by the silence on the other end of the phone you know that it will take a bit of time to designate. If you call them and you tell them what your plans are they can usually respond right away. That makes the whole process quicker and easier.

MR. LEE: That is better. I am glad you made that point. You said a number of things that I thought were right on, including the one about the amount of material that is usually in proportion to the validity of what is submitted. When we get this big, thick package we usually say, what are they hiding?

As Phil said, the original Multnomah County submission was for the underserved population plus the Indian population plus this, that and the other. As I mentioned yesterday, when there are five or six hundred physicians and a good physician population ratio to the county and a low poverty rate, you have to question it. We determined the real problem was, in fact, the homeless population.

As Paul says, if you have a particular problem and it is a little difficult to document, once we discuss it perhaps we can find a way together to do it.

MR. SALLADAY: If there are no further questions, we will move into small groups.

(Whereupon, the meeting adjourned at 2:30 p.m.)

STATE PROGRAMS INVOLVED WITH HMSA DESIGNATION

Phillip C. Salladay
Economist, Distribution and Shortage Area Analysis Branch, BHPr

MR. LEE: Good morning. This morning we have a few presentations to round out the information that we have been trying to present these three days. We have had a study done recently of state programs dealing with shortage area designation and service conditional programs at the state level and loan repayment at the state level. Phil Salladay is going to tell us something about those, and then I will talk about some new developments relevant to HMSA designations that have been occurring and cover those things we have not yet had time for. After our break, we will ask people from the work groups to present the issues discussed and their recommendations from the sessions.

MR. SALLADAY: Good morning. In addition to the Federal programs that use the HMSA designation, which have been discussed so far, there have been around 140 programs developed by states aimed at improving geographic distribution of physicians. The Bureau of Health Professions recognized the need to have current information on the contents and extent of the state programs and developed under contract a Compendium of State Health Professions Distribution Programs in 1986. The Compendium was an update of an earlier effort done in 1981 at the University of Michigan. A copy of the Executive Summary of the Compendium is included in your workshop packet. I also have a copy of the complete compendium here. If you would like to look at it to see what is listed under your state, feel free to later.

Also we have a limited number of copies available. You can order one from our office by using the request form included in your packet.

The 1986 Compendium included 113 programs in operation during the 1985-86 period when the information was collected. In speaking with a number of you in the course of this workshop, I have learned that some of the state programs listed in the Compendium have terminated while in other states new programs have been initiated. Also some of the state scholarship programs are now facing similar pipeline problems to the NHSC.

I want to briefly address the various types of programs that states have implemented. First is selective recruitment to undergraduate medical schools. Preferential treatment has been given to in-state applicants, those students who appear predisposed to practice in rural areas. This strategy has been employed by all public and some private medical schools. Included in this category are programs aimed at recruiting minority students and persons from underserved areas after completion of their medical training. The success of these efforts are difficult to judge by themselves since they are often integrated with other types of incentives.

The second category of state programs are efforts to influence specialty and location choices during the educational process. These include a number of types of programs aimed at increasing primary care residencies. Among these are subsidized family practice residency programs and grants for research in primary care. In addition, although they are not specifically listed in the compendium, 39 states provide funding to support their public medical schools.

Another type of program that is listed in the Compendium is in states that do not have a medical school. A good example of this is the WAMI program where students from Alaska, Montana and Idaho enroll at the University of Washington. Its preceptorship is the principal type of curriculum change programs that seeks alternatives to hospital focused medical experience. These include rural and inner-city programs that emphasize practitioner involvement with the community and provide care to underserved populations. That community involvement might be in the form of physician participation in health fairs and local medical clinics.

Another important program is the area health education center, or AHEC, program. AHECs were initially federally-funded but, at this time, most of the funding comes from the states. Twelve AHECs were identified in the Compendium including Arizona, Massachusetts and Maine. AHEC efforts have been directed at dentists and allied health professionals as well as physicians. They are intended to reduce professional isolation in rural areas. Some AHECs have also sought to increase physician awareness of some social medicine issues, including alcohol abuse and teenage pregnancy.

The third and largest category of state programs involves financial incentives to locate in certain areas within a state. There were a total of 39 financial incentive programs in 26 states when the compendium was compiled. These were either in the form of loans, scholarships or grants. Thirty-five of these programs require that recipients serve in shortage areas. There were around 2,200 students participating, but unfortunately in terms of outcome only 454 face stiff penalties if they choose to buy out rather than serve in shortage areas.

The fourth category of state programs is aid in maintaining and establishing practices. The 32 programs in 20 states are designed to assist underserved communities wishing to acquire physicians or to assist physicians in finding communities where they can establish practice. I think in a number of states that activity is conducted through the Office of Rural Health at the state medical school.

A very important point in terms of HMSA criteria in the state contingency programs is that 21 out of 61 programs using shortage area criteria do use the HMSA criteria or a slight modification of it. Those states using the HMSA for their programs reported major reasons for doing so. A number said that HMSA methodology, while not perfect, are sound and useful for their purposes. Others indicated a preference for having Federal programs bear the expense, provide necessary resources for undertaking the process and, equally important, absorb the dissatisfaction from state professional societies or unsuccessful applicant communities. It does give you the chance to shift the blame to us if that situation arises.

Thirdly, while a number of states expressed preference for developing their own criteria, they lack the necessary staff. In some states, efforts were under way to keep state criteria, but because of funding cuts, such as in the state of Michigan, they fell back to using ours.

Now, the last area I want to cover from the Compendium is the outcome from the State Health Professions Programs. While specific outcomes varied from state to state, the contractor noted three general statements about the outcome of the programs. First, different multiple strategies have a better chance of success in attracting and maintaining physicians than having a single strategy. An example of this may be a selective recruitment program combined with a rural preceptorship and financial support through a service contingency commitment.

Secondly, service contingency programs are an effective but expensive way of placing health professionals. While preceptorships and other curriculum changes are less expensive, they also may be less effective.

Thirdly, service contingency programs with high buy out penalties are an effective means of temporarily recruiting physicians to shortage areas, but more permanent retention of physicians may require additional commitments of programs and resources. So it is an ongoing program or process to keep the physicians in the more isolated rural areas once they have located there under the service conditional or other program.

There is one other item that was mentioned in the Compendium but went beyond the scope of their efforts. What is involved is state efforts in assuring primary care through the efforts to assure the survival of the rural hospitals. In the Compendium they mentioned programs in a few states including Minnesota. We have gotten quite a bit of input on that subject in terms of rational service area and frontier areas. That was not included in the compendium but we are certainly more keenly aware of that now than we were before we came to San Diego for this workshop.

Luci Phillips mentioned an interesting new program in the state of Washington. I am going to try to increase state participation here by asking Luci to tell us about that new program.

MS. PHILLIPS: I am sure the Reagan Administration will approve of this because it is private enterprise helping out. The University of Washington School of Medicine is giving $35,000 a year for the next five years to be loaned to any third- and fourth-year medical students in the amount of $5,000 per student per year. After the student obtains a license to practice medicine four years after the first loan they are eligible to have ten percent of the loan principal plus accrued interest postponed if they practice in an area designated by the SHPDA. At the end of a year's practice in a designated area, the ten percent principal interest is cancelled. This continues for a maximum of five years.

They have 50 percent of their loan paid off. The program's thrust is for the new MD to practice in rural areas. This includes correctional institutions regardless of locations. The SHPDA has a rural access project to identify those areas vulnerable, where the rural hospitals might go under. What would happen to the people then, and we have identified 29 additional rural census divisions in addition to the HMSA designation. The Dean said okay, we will throw those in the pots of areas that will be health eligible for students to serve in. He also added that our migrant and seasonal farm worker clinics were actually in areas of our definition and were urban rather than rural. They are serving the rural population so those clinics are also included among places that are eligible for these medical students to serve in. This started up this last winter quarter. About seven students applied and three were accepted for the loan. I believe that they are using criteria such as whether the students originally came from rural areas. If they are third-year students, they could have accrued $10,000.

MR. SALLADAY: Any other questions or does anyone wish to add to this subject?

MR. MCGINNIS: Yesterday, during our presentation about other programs, I was asking whether or not a foreign student, looking to go to a HMSA, has established U.S. residency by practicing in a shortage area? Why would someone who is a non-obligated foreign medical graduate seek a HMSA?

MR. SALLADAY: I think they were probably seeking to become permanent residents of this country through a program known as Schedule A Labor Certification. Dick Lee will be discussing the status of that program. Any other questions or comments?

CURRENT DEVELOPMENTS IN HMSA DESIGNATIONS

Richard C. Lee
Chief, Distribution and Shortage Area
Analysis Branch, BHPr

MR. LEE: Let me start out by mentioning that in connection with the talk that Phil gave, the Bureau of Health Care Delivery and Assistance, Primary Care group, when they found out we were doing that study participated in finding out what the numbers were of people who were going through any of these different state programs. Whether, in fact, there would be physicians and others becoming available who could be placed in community health centers by cooperative work between the Feds and the states involved. So we did furnish what information we had to the primary care people. They are a little unhappy that we could not tell them exactly how many physicians were coming out of each program, but at least by having this compendium they know what programs exist or what programs existed as of 6, 12 months ago when the study was completed.

In addition to that, along the same vein, many of you may know Billy Sandlin who was, at one time, director of the National Service Corps and more recently before and after that director of the Migrant Health Program. He has retired from government service. He is a consultant with a group called John Short and Associates. In that capacity, he is developing, with input from whomever he can get to furnish consultation, and among other things by using the compendium, a state strategy draft specification for a model state health manpower service conditional program. There are several specific states that they are working with. But the idea is to come up with a model program that perhaps could be implemented in those states that do or are still interested in redirecting physicians in their state. He has developed a list of some of the problems with the existing state programs such as that many do not prioritize placement among areas in the state. They do not typically require commitments to primary care. Most, as Phil was mentioning, do not identify specific shortage areas. There is a feeling that by being a little more selective about where the individual came from you might be more able to get them to follow through and serve in a rural area by picking up people who came from rural areas.

In any case, this report is being used and other things are being tried in an effort to come up with possible directions for future state level programs that could be Federal and state things to improve access to primary care.

I would like to discuss the labor certification program. Back in 1976, at the same time the new criteria were mandated by regulation, the same legislation required that we provide data to the Department of Labor for their use in providing appropriate certification to foreign physicians seeking admission to this country. The requirement was that we provide data by county and specialty in order for DOL to make decisions about which physicians should be allowed to enter the country and go to areas with an inadequate supply of physicians of their specialty.

We got together this wonderful data from our data base and shipped it to the Department of Labor. They returned it asking for a list by specialty in those areas of the country in need. I do not know why we agreed to do this, but we did. We got involved because when you are dealing with foreign physicians in labor certification, you must indicate that there is a shortage and they won't displace U.S. physicians and depress the salary if they set up practice in a particular area. In fact, we ended up giving certification for areas that the physician could use to get a VISA, come into the country and theoretically go to that area. But there is nothing binding on him to stay in that area. What we did in connection with this program was use the HMSA list for primary care specialties.

Eventually we asked our regional people to let us know what had been going on and whether the doctors certified had actually stayed in the area for any length of time. It was a bit difficult to determine this, but we did make an effort to go back and check the people certified to see if they were still there. The results of that report indicated that the retention rate essentially was pretty poor. Many physicians never got to the areas they were certified for. Others went and didn't stay long. In terms of a tool for redirecting physicians or meeting the needs of areas in shortages, it didn't seem significant.

The context in which the question came up was shall we update the list? Shall we have service areas that are more appropriate for these different specialties? More recent data? How much effort should we expend? Howard kept saying we don't have time for it. You have all you can do handling the HMSAs. He was right. But my feeling is if you are not going to do it right, don't do it at all.

Basically the decision of the agency was if something is not worth doing, it isn't worth doing well. So, a letter was written from the Assistant Secretary for Health to the Secretary of the Department of Labor saying we really want to get out of this. We don't think it's worth doing and essentially why don't you take physicians off Schedule A and let them go through the regular labor certification process, which involves the hospital or whatever unit wants to hire them. They have to show that they have advertised in the United States for a physician. They haven't been able to get one and it won't depress the wages. They reluctantly agreed to that. They sent us drafts and so forth. It was published. We did not include that in your packet, but we can furnish it if you wish.

If you look in the Federal Register for January 24, 1986 you will find the proposed rules by the Department of Labor that removes physicians from Schedule A entirely, even in shortage areas.

Our problem now is that as a result of the decision we phased our Bureau people out of the regional office. What they were doing was related to the labor certification program, which we decided not to have this particular effort. You no longer have anyone in the regional office who can do this for the Regional Health Administrator. The NPRM was published last January but they haven't come out with a final rule yet. We are still waiting for that final rule to be published. We are no longer certifying areas as having shortages for the purposes of the labor certification program. That makes a short story long.

If they call up, basically what we do is refer them to the Department of Labor. Unfortunately some DOL people haven't got the word, and are still referring back to us. It is rather unfortunate because individuals are caught in the crossfire.

Any questions on that particular program before I move on?

MR. MCGINNIS: Is it foreign individuals, not just foreign medical graduates?

MR. LEE: It is foreign physicians who are seeking entry to the country. They may have taken training in the United States, returned to their home country, completed residency and now coming back. Or they could be people who have done residency here.

Other questions on that program?

Originally I did not have it on the agenda, because as far as we are concerned it is over. We are not going to bother you, but people still call up and ask questions. I wanted to give you the background.

I would like to move on to the homeless population. What I have received is the Congressional Record of March 3, 1987, containing the bill introduced in the House.

It has passed in the House. It would still be pending in the Senate if enacted in its present form by the House. The Urgent Relief for the Homeless Act reassures grants for the homeless with authorization of $75 million.

It also includes an authorization for community-based mental health services for homeless, chronically ill with an authorization of $25 million that includes grants for facilities to assist the homeless by HUD, with the advice of our department. That is in the $75 million. There is an emergency food and shelter provision from the Federal Emergency Management Agency for $20 million. Emergency shelter grants, housing and urban development get $100 million. Emergency Community Services Homeless Grants Program from HHS for $50 million. I am not sure how that will tie in with the others. Housing for handicapped and homeless receives $25 million.

It is a very complex bill with many distinct subprograms. Someone must have gone through and found the Federal program that in any way related to the homeless and said, let's give that a shot in the arm. The part that relates to the Department of Health and Human Services is the grant for health services for the homeless. This creates a new Section 340 of the Public Health Service Act, which would enable grantees directly or through contracts to provide for delivery to homeless individuals of outpatient health services at locations accessible to homeless individuals.

Secondly, they would have to provide emergency health services at all hours. They would have to provide referrals to medical facilities for inpatient services where necessary. They would have to provide outreach services to inform the homeless of the availability of these services.

These health services would be run without regard to ability to pay on the sliding fee scale, most likely at zero. Then the grants would be the people providing the services up to 75 percent of the actual cost of the services unless the applicant is a Section 330, nonprofit private grantee. In this case they could take 100 percent.

The term homeless individual means an individual who lacks housing, without regard to whether the individual is a member of a family and including an individual whose primary residence is during the night at a supervised public or private facility that provides temporary living accommodations. Then comes the part that relates specifically to HMSA designation that amends Section 332 (A) to say as a homeless individual is defined in the definition may be a population group under Paragraph I.

We can handle these designations under existing criteria. With 3,000 homeless individuals and one or less people serving them you have a designation under the existing criteria. It may mean revising the authority that they are trying to say we want you to develop specific criteria for homeless designations, in which case, we could do that. That may be a logical reason for saying 3,000 to 1 is fine for most population groups, but it isn't fine for the homeless. You need 1500 to 1 or some other figure as an alternate designation of the homeless. If there is a definition of the homeless they are automatically designated similar to what we do for the Indians.

MR. LABREC: You are defining rational area. We talked about populations who would not fit into that paragraph -- established neighborhoods, etc. There is a large turnover, about 60 percent in Phoenix, of homeless every few months. You have to revise the data or at least realize you are not talking about the same kind of communities. It is quite different.

MR. LEE: You are referring to the fact that in the population group section of the criteria there is a sentence that says the area they live in must be rational.

MR. LABREC: Under the rational area criteria, etc.

MR. LEE: I think we can handle that with recognizing the counts as rational service area in most cases. Most of these homeless populations are going to be within one county or one city.

MR. LABREC: Just recollecting, they are a very transient population too, not at all settled.

MR. LEE: Obviously. The big problem with the homeless is counting. If you can come up with an estimate. If that is going to be a program serving the homeless, someone must make the effort to count them in order to find out how to provide the services. By focusing on it the count should become better. If we are able to count them it will be easier to designate. We can handle it under the existing criteria, and revise it to make it better for the homeless.

MR. SALLADAY: If the existing community health centers who are applying for funding can get it without submitting any kind of designation request, why would they try to get the area designated?

MR. LEE: The existing clinics can apply for funds to serve the homeless, but if they want National Health Service Corps personnel, such as a clinic that serves and MUA but not a HMSA, then they need to be designated. It could be that the clinic wasn't in a city with a HMSA designation and the population group was designated as an MUA and they had too many physicians. They just want us to be particularly responsive on this question of the homeless.

MR. GOSSERT: What is the number of that House Resolution?

MR. LEE: It was House Resolution 558, Title 6. The Act is Urgent Relief for the Homeless Act.

The next topic for discussion is the prison facility criteria. We have been working for some time on trying to make a simple change. It was brought to our attention that in the correctional facility designations a facility with a high turnover may have five or six times the inmate population overall as compared to any one time. The existing criteria as they are published and implemented create a weighting where you are really overstating the health service needs of those prisons.

As a result you have prisons where the designation threshold is 20 physicians. We have developed a proposed revision to this and have spent much time with different drafts. I have given you a copy of the draft entitled a technical amendment. We are changing the definition of internee in order to lead to a more rational result for the requirements generated for the prisons. It is a function of the lengths of stay and the percentage of STA exams handled by a physician or dentist or others posed to a physician assistant.

Incidentally, the first two pages are preamble. The last page, on the flip side of the second page, contains the actual definition as it would be changed. The effect of this is that the total number of internees can never be more than twice the number of inmates in the particular facility. Consequently, you won't get these ridiculous designation thresholds in those institutions.

We were told at first that it could not be done with a guideline or a technical amendment published over the signature of our agency administrator as was done with the definition of non-Federal a few years ago. We were told that you have to go all the way through because you are actually changing what particular prisons are affected by this. Some facilities will lose the designation. You have to give them a chance to comment. You have to publish. We are still fighting that battle. We got to the point where people in upper levels were saying, wait, this looks like a relatively simple thing. Hopefully, something will be published sometime this year, if we are lucky. By the time we get the thing through and implemented it will be an idea whose time has passed. There was a prison health initiative a few years ago that was one of the things that sparked this initiative to change this regulation.

Any questions on that?

As new requests for prisons come in, we are trying to implement this as much as possible so that we do not have in place additional designations under the system we think is wrong.

I would like to mention that we developed a few years ago a provision to the mental health shortage criteria. Currently we have a psychiatric shortage criteria. We looked into the possibility of broadening that to include not only psychiatrists but psychologists and perhaps even clinical mental health social workers and psychiatric nurses.

An approach to doing this has been developed, but requires information on what you are doing in any particular mental health function and the relationship between these different mental health providers. The simple way of looking at it would be how many psychiatrists equivalent to how many psychologists equivalent to how many social workers. That is too simple for mental health professionals. They want to establish a 2 to 1 or 3 to 1 correspondence. Instead, we looked at finding a function that mental health department professionals performed this function in what relative ways for that function. So, you would develop a requirement for the population and then from whatever mental health practitioners were the actual supply and compare the two. It is a fairly complex methodology but there is a whole system of ways that we need to make the system work.

The Alcohol, Drug and Mental Health Administration (ADAMHA) agreed to participate in determining what these ways would be. We determined a survey and sent the survey through the system to the Office of Management and Budget for clearance. It may come as no surprise that we heard it was rejected. Whether it can be, that is consistant with what has been happening in all health professional surveys over the last few years. We may resubmit and get approval. We may take a scaled-down version of the criteria and somehow make an adjustment of the existing criteria without doing the survey. We must decide to what extent it is worthwhile. ADAMHA has a significant number of programs involving these other mental health professionals. There is a body of people to be placed in shortage areas. It would be better to have a refined set of criteria for defining them that did not pretend that only psychiatrists exist. The whole idea is in a stage of flux due to the rejection.

Howard mentioned loan repayment. Under consideration are legislative loan repayment proposals that would allow "x" amount of loan repayments to be given on a year-by-year basis. The initial emphasis would be on primary care. It is also possible, particularly since the health program and other programs have already in the statute a reference to possible loan repayment, that at some point along the line, perhaps at the congressional level, it would also be authorized for other health professions. In that event, it would relate to a study we did several years ago of existing optometry, pharmacy, veterinarian criteria because we felt they needed work, particularly podiatry. We had a tremendous number of shortage areas as compared with the other non-primary care physicians. We said we could change the criteria to more sensibly identify the real shortage areas for those other disciplines. We did develop some methodology for that. We also wanted to update the designations but before we got all that in place, the Health Profession Students Loan Repayment Program was disbanded. We rationalized that if and when a loan repayment program would be authorized for these health professions, we would pull those studies out, and we would have saved some work. I think the methodology developed was good and could be implemented. Obviously we would have to get the most recent data. There are some potential revisions of shortage criteria should it become necessary.

Public Law 9928, the Health Services Amendment of 1986, passed last April, revised Section 330 (B) of the Public Health Service Act in such a way as to expand on the definition of medically underserved populations and to require regulation describing criteria for them. That little piece of legislation requires that in fact to call them something different. It calls them criteria for determining the specific shortages of personal health service of an area or population group. That is the new definition. It requires that criteria be expanded by regulation and that the criteria take into account the comments of governors and local officials. That the criteria must include infant mortality and other health status indicators, ability to pay, accessibility and availability of health professionals. Prior to a designation or termination of a designation we used the term withdrawal.

The second must provide notice opportunity for comments and must consult with the governor, local officials and the state organization, if any, that represents the majority of community health centers. Then, populations not meeting the published criteria could be designated. It says, "may be designated if the governor and local officials recommend it based on unusual local conditions that are a barrier to access or availability."

Now BHCDA has the authority to designate in connection with the community health center program. They initially proposed essentially using the existing MUA criteria.

We suggested a few things to BHCDA including that they adopt existing HMSA criteria, define local officials in their draft as county executives and mayors, governors and primary care organizations, and that the exception procedure be very thoroughly defined. In this way you can control the number of exceptions granted when a situation does not meet the criteria, but governors and local officials recommend designation.

The regulations are still being drafted. We have also commented on having some coordination between MUAs and HMSAs, but that is still in flux.

MR. GOSSERT: If regulations are being written, I assume that would mean that if a governor of a state decided he wanted to use this procedure for designation, until the regulations are in place, it would not be possible?

MR. LEE: That would be my assumption as well. There is no regulation in force. The law is in force and the governor and mayor can write and request a designation as an MUA. Can they do it? I would say so, except the criteria must be published by regulation, and they cannot designate until criteria are published.

MR. SALLADAY: Why is the MUA being restructured? Is there new money for establishing new clinics, or just funding for existing clinics?

MS. HONDA: Community health centers have to go through review and reevaluation every year to three years depending upon the length of their project periods. MUAs are looked at time again. Secondly, every year there is a small amount of money available for new clinics and community health centers.

MS. CAGEN: Does that mean if a health center was to become a center but cannot designate as an MUA, how can they follow through? We have a health center in Rhode Island that is applying for that.

MR. LEE: I wanted to update you on the legislation and the fact that regulations are being worked on and are not yet published. What their current procedures are in the Bureau of Community Health Centers Assistance for actually getting a designation implemented, I do not know.

MS. HONDA: I would assume that until the regulations are published, the existing process would be followed.

MR. LEE: That raises the question if Congress tells you that it must be put in a regulation and you are using existing criteria because it is easier, it may not go over well.

MR. MCGINNIS: My most recent correspondence from BHCDA regarding medically underserved areas was a letter that requested that they not be submitted, that the Bureau did not wish to review any medically underserved areas. I believe it was dated 1984. They have not sent anything to indicate that they wish to update or renew any designations we already have.

MS. GLIDDEN: I have submitted requests for MUAs for four different areas under the special designations. Most recently I have received notification on one and preliminary answers on the others. So they are still designating.

MR. LEE: My last comments on the frontier issue is simply to say that based on the interest that has been expressed plus what we have heard here, Howard and I are going to further investigate what can be done with that issue and relate it to the current efforts that are ongoing. The task force and what changes, if any, we should make in either the criteria or the procedures for designating rural areas that are frontier areas.

We will look into that and try to coordinate with the task force not only for MUAs but also for HMSA.

PRESENTATION OF ISSUES AND RECOMMENDATIONS FROM SMALL WORK GROUP SESSIONS

Justine Ceserano, New Jersey
Dean Hungerford, Idaho
Paul LaBrec, Arizona

MR. SALLADAY: Our first presenter is the representative from Regions I and II, Justine Ceserano from New Jersey.

MS. CESERANO: The consensus of our group, Regions I and II, is that there is little recognition on the part of our agencies, the state Department of Health for the most part, regarding the value of the effort and time spent on HMSA designation in view of the limited number of physicians we will receive as a result of our efforts. It is becoming very obvious to us that more time will be necessary as the community resources such as the HSAs are eliminated. We lack not only recognition but, more importantly, support from our agencies. As such, we are suggesting that the Federal government contact the higher ups in our state, government authorities and commissioners of health, preferably via letter, making them aware of the HMSAs designation and their continued support despite the decrease in National Health Service Corps resources.

People need to be made aware of the other benefits of the designation process. Howard mentioned there are at least nine other programs tied to the designation process. I believe that our commissioners and governors need to know how their individual states can benefit from these programs, how these programs can be made applicable to the individual states. We feel it is essential that the support for our efforts begin at the top and filter downwards since our attempts to work from the bottom up are not working.

Our second recommendation focuses on further information relating to the Federal programs tied to the designation process. Dick alluded to a brochure that would be published outlining these programs. We feel that dissemination of this is vitally important. We suggest that you include within this brochure a contact person and telephone number. This information needs to be sent directly to the attendees of this workshop as the people most directly involved in the activity on a state level which would relate to these programs.

It is obvious that as we are better informed, we will become more effective in performing our jobs.

MR. LEE: I will briefly comment on these suggestions. Howard and I have been working on a letter to the governors that would ask them to redesignate the people in their state they want involved in HMSA designation, particularly governors in those states where the SHPDAs are disappearing. I think you are suggesting a broadening in emphasis of the importance of the HMSA designation.

MR. STAMBLER: We will be doing that and adding to it. The other suggestion made regarding state health department commissioners is an important part of the process. We have been at a distance from them for a while. We will definitely follow up.

MS. CESERANO: To reiterate, the important thing is to make them aware that these designations are not only linked to the National Health Service Corps doctors, but to other programs as well.

You should broaden it to make it clear that these groups are of benefit to the individual states. We have gotten the feeling that there is no state support.

MR. STAMBLER: Further information on the programs will definitely be sent out. We will prepare a fact sheet on these programs with the information on contacts and make an attempt to get more detailed information on the specific programs in specific states with a person who may be of help in a variety of things.

Commenting back on the letter, since many of these people are in the political process and their learning period is fairly short, it seems a little self-serving. Instead of asking them to redesignate, it would be well to point out those who are already designated and reinforce what is in place.

MR. LEE: Part of the letter containing what we are working on with so-and-so on your staff.

MR. SALLADAY: Our next presenter will be Dean Hungerford from the Region VIII and X small group discussions.

MR. HUNGERFORD: I guess the way to be popular here is to be brief. One reason it is possible to do that is that Dick removed the smoking gun that I had here since most of our time was devoted to discussion of the problems of the frontier areas, by saying that you already plan to take another look at the criteria or the process by which the criteria is applied will deal with the major issues we have.

In Regions VIII and X, most of the state have serious problems in the rural areas. We talked about the general economic downturn in many of these states that in turn affects the economy, which are particularly devastated in these small areas where it is essentially a one-industry type of employment.

You double or triple the effect when that particular industry has downturn, which affects the ability to maintain health services in those areas. We feel the bottom line is if the criteria are adjusted to take into account the peculiar trade patterns that exist in some remote rural areas, the very reason they are classified as frontier can denote problems in delivery of all social services.

That would go a long way not only towards the designation process but in the deployment of providers once they are recruited. There was some discussion about whether or not designation as a frontier area has a negative connotation in recruitment, but we decided it was not necessarily negative but could easily be.

The other problem we discussed was that many of our states lacked resources now. The National Health Service Corps contracts and the primary care cooperative agreement have helped in some cases but those resources are limited and probably not going to be extended to those states that do not have them now. It does fall to the responsibility of the state, so encouragement for states to help support that system would be helpful.

Lastly, I wanted to mention a recommendation mentioned in the general session here as well as in our small group discussion, the possibility of using zip code boundaries in designating service areas as well as the county civil divisions. It was pointed out in our group that in some cases, it continues to work but where it does, census and health data are available to use in determining areas based on zip codes. It would be an available option.

MR. LEE: I would like to respond to the third suggestion first. The problem with using zip codes is simply whatever the area is, we need the population and the number of physicians. If you use civil divisions or census tracts you have the population data. If you use zip codes you know where the physicians are by zip code, and you have the physician count. The problem is you have to go one way or another. You either have to find the population of the zip code areas or the number of physicians in the census area. The reason we don't use zip codes is because we don't have population by zip code.

This has typically been easier to determine which physicians are located in the census divisions as opposed to what the population is.

MR. MCGINNIS: We have level 3 information from the census by the zip.

MR. LABREC: We are doing an assessment now as part of our agreement, working with the zip codes. It is not true in all states, but in some of the larger, rural states can fit the communities into the zip codes. There is not much hairsplitting of boundaries. It is difficult in some cases, but we are trying to make it work.

MR. LEE: I was responding to the general situation, nationally. We know what the populations are by the census data, but we do not all know what it would be by zip code. If you have an area where you know the population by zip code there is nothing preventing us from entertaining that idea.

Number two, is there a specific recommendation about how we might handle the frontier issues?

MR. HUNGERFORD: One thing mentioned very specifically was travel time. The fact that in many rural areas the traditional trade patterns and distances to do shopping for either goods or services is much longer than the normal 30-minute travel time. You can give consideration to that.

FROM THE FLOOR: One of the points was to look at each application to test our own general consistency. The name frontier is very isolated and it is hard to develop a consistent pattern.

MR. LEE: I would say in the case of a frontier area, we would relax certain criteria in certain ways. We would not go from 3500 to 1 down to 1000 to 1, and we wouldn't go from 30 minutes to two hours, but we would be looking for some specific ways to broaden certain areas. You are suggesting a case-by-case basis. We might do that. That gets scary, and it is better to have a specific approach. What we need is to walk out of here with a list of those people who wish to help with the frontier issue. We already know the task force, but other people got on board in this group so we can keep in touch.

MR. STAMBLER: It will take work on our part, which makes us a little queasy. We like to have a criteria, something in writing that cannot automatically designate but can take into account the frontier problems. The main thing that would come out of this is that I will write and recommend to the Administrator that this be looked into. It is not going to be very simple or quick, but we recognize this is an important aspect or reflection of the changing health care patterns. This came out of the workshop and I will make the recommendation to change the criteria.

FROM THE FLOOR: Some of the information that the task force developed we volunteered to send to you so you have the same information that Ed Martin has and BHCDA is working at.

MR. LEE: If we can get some cooperative kinds of criteria out of this it would be great to see all the different Federal bureaus somewhat synonymous.

MR. SALLADAY: Our third presenter is Paul LaBrec from the small group discussions in Region IX.

MR. LABREC: Actually I was just asked by David to make some comment on the Wednesday session on geographic HMSAs in Region IX. We spent most of the time talking about common problems and the types of resources we used in our states in sharing those types of information. Some of the main things we found for our southwestern states are the very large counties that are often not rational service areas. Where most of you are going by county level, it doesn't work well in states like Arizona where there are only 15 counties. We tried using levels like CCD and ED and even zip codes if we can in certain areas.

We note that we tend to use a greater amount of narrative description to define our rational areas because we are going in smaller than counties. We need to take into consideration travel times, etc. We need to consider access barriers such as topographic barriers, poor roads, mountains, lakes and such. This was mentioned before the size of certain rural communities. You might be talking about distance that would seem rational although many people don't use certain services for historical reasons. Certain communities prefer to go to certain places for their health care.

Finally, the availability of data bases is a problem in our rural states. For levels below counties we seem able to get that for state and county, but we are trying to work with units that are smaller. It is real difficult to get vital statistic data at a level below county. We have had to use creative methods to work through that. Often we look at the county data and then use narrative descriptions to describe what part of the county we are talking about and how these figures are different.

Some of our states varied a bit in the availability of central data bases. Arizona seems to do pretty well. California had many problems with it.

Also the centralization of organizations that are doing the HMSAs and applying for HMSAs often result in questions from CHC directors and other local individuals who do not know how to contact the people doing HMSAs.

In some states, people who are concentrating on certain regions rather than others just because of the domain that they are responsible for. That is a problem in coordinating the activities of an entire state.

MR. STAMBLER: We recognize the problems, and if feasible, we may try to find some Federal sources or other agencies not necessarily connected with the traditional ones that may be able to help.

I have mentioned to some people that state health agencies that may not be anywhere near you in the state may have data, some good and some bad. These are agencies funded by the National Center for Health Statistics. In some cases medical schools will have the information. They are doing studies on physicians and health manpower for their own purposes and needs. That might not have come to your mind in terms of finding data, although we often assume that state people know their state and its resources in terms of data better than we do. Data can be very difficult to come by.

MR. BRAND: Irma and I had a conversation this morning and she assured me that the only source of information that we are really going to have in California for the forseeable future is the level of clinic director. The problem became clearer as we talked about it. How do we get the necessary information to the clinic director. Often, when we want to do a combination or original designation, we use a lot of staff time. When they submit the application, I have to go back to them for many things and it takes up more staff time.

What we were talking about was that she can get a hold of the particular area clinics that have designations coming up in 1984 where people are placed or on the staff and ask them to call me. I don't mind making 40 phone calls if that is what it takes. I was talking with her about the possibility of some kind of collective device to get the information to them.

MR. LEE: I am a little concerned because we had asked for a representative for California. Ed Smeloff was designated but did not show up.

We had also asked for someone from the primary care association, Mr. Diaz, to be with us. He also did not make it. As a result we have Yolo County represented but not the rest of California. Chris Walker is here, but we don't have a broad representation of California.

MS. HONDA: First, there is no one PC association in California. There are 13 PC associations in California, a part of the problem. The reason that I mentioned to David that we would have to depend on the clinic director is because they have the greater interest in maintaining the designations. At the same time, it is not a priority with the state and we cannot depend on them to do the work as in the past.

MR. MCGINNIS: Our group didn't really discuss it, but I did want to put in another bid for my friends at the Oregon State Hospital, that psychiatric committed people do have primary care needs and that criteria do not allow for the designation of psychiatric inpatient institutions as primary care and health manpower shortage areas. I have written to Phil to that effect.

MR. LEE: Yesterday afternoon we had discussion on rural and migrant and Hispanic speaking groups. I wonder if someone in that group could report on that.

MR. LABREC: Most of our time was spent discussing how to count migrants. We threw around some methods, one of which was that people were using the so-called Larson method. It is technically the methodology designed to estimate target population. It is out of the Office of Migrant Health.

There were some labor statistics from the states we were trying to estimate. Some of the states were carrying on various independent research studies to determine the number of migrants. No one can really pin down for sure. In some states there are larger numbers of undocumented workers in certain areas. Those you will not get labor statistics for. We are trying to go to the growers and employers themselves. That was the biggest problem we had in counting migrants.

Also, certain people stressed the need to identify the linguistic and cultural barriers when talking about migrants. It is important, you have to stress those in your applications. Also when you are talking about migrant and seasonal farm workers, it's not a homogeneous population, there are different strata within that population, different health problems and health needs within a migrant and seasonal population.

MR. LEE: I was kind of looking for whatever recommendations might have come out of that group or any recommendations that anyone here wants to make about that. I suppose one of them is a distribution, if in fact, the Larson study has a methodology that would be applicable.

MR. LABREC: That is one method. We were trying to share ideas and different ways. There is not a real great method to do this. You have to employ a lot of different types of criteria.

MR. WALKER: If the Larson method is the one I am thinking about, it depends on the time of harvest and then look what the populations needs would be for harvesting groups. The problem we ran into here that people might want to be aware of, it doesn't take into account planting and maintaining time. It can vary a lot. For example, we have a lot of avocado growers. The harvest time is what you are looking at in terms of labor, but with strawberries there is time spent planting and maintaining those crops. So that adds on a lot of labor.

MR. LABREC: That is one thing we were talking about. When recognizing that we were talking about different crops and different migrational patterns, etc. We have a steady migrant stream for the most part. A lot of the workers there live across the border in San Luis. It's a commuting situation rather than a migrant situation.

MR. LEE: Do they get involved in the planting and the harvest?

MR. LABREC: They are doing certain things part of the year. They are working and the other times packing also.

MR. LEE: I think you are referring to a more recent study. There is a current effort sponsored in part by the Office of Migrant Health to count crops and from that develop new estimates to replace the 1978 study. That is the one I think you are referring to. That's a good point that they need to take into account the planting time. I don't know how we would take that into account. Certainly in the amount of months of years that they are in the area not including the harvesting months but also the planting months.

MR. LABREC: I think it's also important to get to know more about the population if you are going to try to develop HMSAs for migrants. The objective is to develop service. You have to know about what the current pattern of service use is for that population. We have run into the insurance situation. You look at how the workers are insured. A lot of times if they are under large plans certain providers are identified. There is a clinic in Yuma at which a large number of workers get their care paid for. Others have to go to Mexico and one particular clinic in San Luis. You have to recognize those patterns. You might not get someone to come to the clinic because it won't be paid for. There is a lot more to be considered in designation of the migrant population.

MR. GOSSERT: One of the problems is I am not real familiar with the Larson study, but the discussion about using the labor numbers on existing migrants is useful.

Colorado has a very poor source for figuring out how many migrants there are. Very few migrant laborers go through the normal Department of Labor. There are lots of so-called crew leaders who go out in Texas and recruit people and bring them into Colorado. Our department knows nothing about them. The information we get from our Department of Labor is only a fraction of the migrant labor.

MR. LEE: The migrant counting and the homeless counting are essentially impossible tasks. All we can do is work with whatever data sources are available. I guess we have a tendency to prefer more recent sources than the 1978 study that developed some estimates. So if somebody has a State Department of Labor that has some estimate I would tend to give weight to that, at least that is more recent.

Basically I guess we need the Larson study and also whatever the acreage and adjust for planting. We need to come up with some methodology collectively that enables better estimates to be made. That is not enough. I don't know what it's going to take. We should see what the Office of Migrant Health is doing in that regard and try to get some coordination with them.

The one thing that I haven't heard anybody talk about is urban areas and population groups. I am wondering if any of the groups, particularly the group yesterday afternoon, if there were any comments, or recommendations on how better to deal with those kinds of decisions and whether people are generally satisfied with the methods that are now being used on that.

MS. CAGEN: What we basically talked about was urban designations. Mr. Brand was very helpful in giving us come tips on strategies, basically, to put together census tracts, contiguous areas and characteristics. I can't say that I can recall any major problems that we discussed having. A lot of us are new to it and haven't done it or if we have done it, we haven't had problems. It was informative, but I can't give any recommendations for changes.

MR. BRAND: One of the things that was emphasized was the need, as you were saying, to find within large urban areas counties that contain large cities that can't be rational service areas according to the definition of rationally, to find areas that constitute groups of census tracts that are uniformly high poverty. I am not saying every tract has to be 40 or 50 percent poverty tract. I can't be comfortable with, for instance, a tract that has a 9 or 7 percent poverty rate in the middle of two groups that are mostly 30s and 40s. We can't call that rational.

There was a lot of emphasis placed on the necessity, as Dick and I have been doing, to take some of the urban area requests and using less color codes and color. Census tracts that are in small portions of urban areas looking for the clumps of high poverty. On my code it's looking for the purple, red and blue areas. Those are the high poverty tracts. Staying away from the yellow and browns, which are in the lows.

The problem most of us discussed about the possibility of a particular clinic that is serving a poor population in an area in a city that doesn't happen to be plotted in one of the tracts that is in the clump. The suggestion was made to go ahead and try to designate or submit the high poverty area for designation. Submit a designation request as serving that area in the clinic is within 30 minutes of the area you picked. It's usually going to be a tract or two away from the area you picked. We adjusted a little bit the different geographic and population groups within large cities that were somewhat different in the applications. This was necessary to emphasize the areas that are high in poverty. I used several examples from Dade County. It's in a state of flux. There are all kinds of groups moving in that weren't there before. They are having the usual problems with different cultures. There are many small areas in Dade County that have been identified by the Florida State Office and have been designated and redesignated in most instances.

MR. LEE: This is similar to what I mentioned the other day about Dade County which is a large city where there are lots of physicians but there are also some population groups and/or neighborhoods with high poverty or other indicators. The only thing that we have to work with still is the 1980 census data by census tract on poverty and minorities.

So what we have tried to do, and really we started this with the 1983-84 review, is identify the high poverty sections in urban areas and assume that those are where the people are who have an access problem. Then it can be justified that they do not have access to physicians elsewhere in the city.

Obviously, that breaks down in patterns of change since 1980. What keeps coming up is how do we deal with that. That is the problem. I think Phil mentioned one case in Ohio where in fact they have managed to update the poverty estimates but in those states and most areas we don't have anything more recent than the 1980 poverty area. We used that as a base line to define the rational service area. It's complicated.

I was just curious as to whether any other suggestion had been made. Evidently not. That's all I have.

(Whereupon, the presentations for the workshop were concluded.)

CLOSING REMARKS
Howard V. Stambler
Director, Office of Data Analysis
and Management, BHPr

MR. STAMBLER: I guess you can see from this that we are pretty close to breaking. It's a little bit ahead of what we had planned. We have fortunately gotten absolutely fantastic weather, maybe a little bit of time left to enjoy it.

There are a couple of things I wanted to mention in a variety of contexts. First of all, I wanted to thank Deborah Harris and Suzanne Lirette for the wonderful job they have done. They have been on hand to help everybody, both personally and as an organization. Thank you very much.

To add to that, I generally hate people to tell the audience to applaud. In connection with that, please fill out your evaluation sheets. This is important to us. The evaluation sheets are very helpful in getting individual views, topics and suggestions. That information can be very helpful, so please fill them out.

Check out time for the hotel is 12:00, but they tend to be a little bit flexible and we are breaking a little earlier than we had anticipated. You should not have any difficulty. I want to mention that on the back table there are some extra packets for the HMSA workshop. These contain quite a bit of information, as you well know. If you need another packet or want to send it to someone, please do. There are also some additional packets of information from the AMA. If indeed you need one of those, please feel free to take one. As we mentioned, there is quite a bit of new, unpublished information in the packet. You may find it useful and will have a little bit of a leg up on the data issue, even though it's not necessarily directly for HMSA activities. You have something a little bit fresher and newer than probably anybody else does.

We also have in the back a bibliography of the various kinds of reports prepared by the Office of Data Analysis and Management. A list of these is in your packet. If you feel something could be useful to you for a general use, please fill in the form and send it to me. We will see what we can do since you came and worked with us. We always have a few copies of most everything we produce. We just don't advertise that they are available. And, if you do have something that might be of interest to us, let me know. Just send it to me.

This has been a really marvelous workshop and the first one out of the many that we have held in various kinds of areas and regions that we have not just gotten hands thrown up by participants. We have not gotten the kind of criticism that says you are doing a lousy job. What we have gotten is some concrete recommendations and some concrete views on the changes that are occurring in the health care system and are not being covered appropriately by the HMSA criteria. These are recommendations that we will deal with, for example, on rural and frontier. It will take work, but we feel these recommendations are valid.

We will begin to deal with them. This is the kind of thing that means that if approved, whether it's within the agency or not, we will have support. But it's work. Because of the interest and because of the importance of it, I personally promise we will start moving some of these recommendations up the line to see if we can begin the work to change some of the criteria. I think to that extent this workshop has been unusually productive.

I would like to thank our own staff as well. I want to thank Phil, Dick, David and Melba and obviously I particularly want to thank all of you for coming, attending and participating fully and openly. I personally found the talks very, very important. We hope we have gained some knowledge and that you, too, have gained some, and together we can move forward on this entire process.

Thank you very much. And does anyone else want to add to it?

MR. LEE: I just want to echo what you've said. It's all been helpful to us to have you here and to get this kind of feedback. I hope it's been helpful to you as well. Over the years we have tried to get people in the field together so we can see them face to face, form some relationships that make it easier when you get back to the office. What I have noticed is that you talked to each other as well as to us. I suspect that is very helpful to you. I hope it has been. I don't think many of us get together enough. It's not clear that anyone is getting together. I am glad we were able to do that. I hope it was good for you. Thank you for being here.

MR. LABREC: It's going to take a while before the proceedings come out for this conference. It would be helpful if you could draft a brief letter of all the recommendations as you understand them. Let us know what you have heard and how you are moving along so I can call you up six months from now and say "Are you doing this? This and this and that was suggested.

(Whereupon, at 11:15 a.m. the meeting concluded.)

APPENDICES

APPENDIX A

LIST OF PARTICIPANTS

HEALTH MANPOWER SHORTAGE AREA DESIGNATION WORKSHOP

VACATION VILLAGE
SAN DIEGO, CALIFORNIA
MARCH 10-13, 1987

PARTICIPANT LIST

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APPENDIX B

AGENDA

HEALTH MANPOWER SHORTAGE AREA DESIGNATION WORKSHOP

VACATION VILLAGE
SAN DIEGO, CALIFORNIA
MARCH 10-13, 1987

AGENDA

TUESDAY, MARCH 10, 1987

6:00 - 8:00 PM	REGISTRATION	HOTEL LOBBY

WEDNESDAY, MARCH 11, 1987

7:30 - 8:30 AM	REGISTRATION/COFFEE AVAILABLE	MISSION BAY FOYER
8:30 - 10:15 AM	WELCOME AND INTRODUCTIONS	MISSION BAY ROOM
	Overview of ODAM/BHPr/HRSA Organization and Functions Howard V. Stambler, ODAM	
	Background and Overview of HMSA Designation and this Workshop Richard C. Lee, ODAM	
	Overview of Health Personnel Developments and Projections; Trends in Geographic Distribution/ Diffusion of Physicians Howard V. Stambler, ODAM	
10:15 - 10:30 AM	COFFEE BREAK	MISSION BAY ROOM

10:30 - 11:45 AM	**CURRENT HMSA CRITERIA AND GUIDELINES; DESIGNATION PROCEDURES** Philip C. Salladay	MISSION BAY ROOM
11:45 - 1:00 PM	**LUNCH (ON YOUR OWN)**	
1:00 - 2:15 PM	**PANEL DISCUSSION:** **State Agency Experience/Methods/ Issues in Geographic HMSA Designation (State Agency Representatives)** Sophie Glidden, Maine Justine Ceserano, New Jersey Dave Peterson, South Dakota	MISSION BAY ROOM
2:15 - 3:15 PM	**SMALL GROUP DISCUSSIONS (Participant Experiences/Problems with HMSA Designation)**	
	HMSA DISCUSSION GROUP A (Regions I and II) **Moderators:** Robert Lauber Melba Kokinos ODAM	SUITE 710
	HMSA DISCUSSION GROUP B (Regions VIII and X) **Moderator:** Philip C. Salladay ODAM	SUITE 711
	HMSA DISCUSSION GROUP C (Region IX) **Moderator:** David Brand ODAM	SUITE 714
3:15 - 3:30 PM	**COFFEE/COLA BREAK**	EXECUTIVE LAWN
3:30 - 4:30 PM	**RECONVENE SMALL GROUPS**	
4:30 PM	**RECESS FOR THE DAY**	

THURSDAY, MARCH 12, 1987

8:00 AM - 8:30 AM	COFFEE AVAILABLE	MISSION BAY ROOM
8:30 AM - 10:00 AM	**FEDERAL PROGRAMS RELATED TO HMSA DESIGNATION** Howard V. Stambler, ODAM **NATIONAL HEALTH SERVICE CORPS HPOL DEVELOPMENT; PLACEMENT POLICIES AND PRIORITIES** Irma Honda, NHSC	MISSION BAY ROOM
10:00 - 10:15 AM	COFFEE BREAK	MISSION BAY ROOM
10:15 - 12:00 PM	**PROFESSIONAL ASSOCIATION INVOLVEMENT IN HMSA PROCESS/DATA** DeWitt C. Baldwin, M.D., AMA Norbert W. Budde, Ph.D., AMA Kent D. Nash, Ph.D., ADA	MISSION BAY ROOM
12:00 - 1:15 PM	LUNCH (ON YOUR OWN)	
1:15 - 2:15 PM	**PANEL DISCUSSION:** **State Agency Experience/Methods Employed in Population Group HMSA Designation (State Agency Representatives)** Paul LaBrec, Arizona Paul McGinnis, Oregon	MISSION BAY ROOM

2:15 - 3:15 PM	**SMALL GROUP DISCUSSIONS (Emphasis on Population Group Designations)**	
	HMSA DISCUSSION GROUP A (Regions I and II) **Moderator:** Robert Lauber Melba Kokinos ODAM	SUITE 710
	HMSA DISCUSSION GROUP B (Regions VIII and X) **Moderator:** Philip C. Salladay ODAM	SUITE 711
	HMSA DISCUSSION GROUP C (Region IX) **Moderator:** David Brand ODAM	SUITE 714
3:15 - 3:30 PM	**COFFEE/COLA BREAK**	EXECUTIVE LAWN
3:30 - 4:30 PM	**RECONVENE SMALL GROUPS**	BREAKOUT ROOMS
4:30 PM	**RECESS FOR THE DAY**	

FRIDAY, MARCH 13, 1987

8:00 - 8:30 AM	**COFFEE AVAILABLE**	MISSION BAY ROOM
8:30 - 10:00 AM	**STATE PROGRAMS INVOLVED WITH HMSA DESIGNATION** Philip C. Salladay, ODAM **CURRENT DEVELOPMENTS IN HMSA DESIGNATIONS** Richard C. Lee, ODAM	MISSION BAY ROOM

10:00 - 11:30 AM	PRESENTATION OF ISSUES AND RECOMMENDATIONS FROM SMALL GROUP SESSIONS; DISCUSSION ODAM RESPONSE - FUTURE EFFORTS TO IMPROVE HMSA PROCESS Howard V. Stambler, ODAM
11:30 AM	SUBMIT WORKSHOP EVALUATION FORMS
	ADJOURNMENT

BHPr

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Health Professions